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State of Maryland / Department of Health and Mental Hygiene

96 13001

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GIACHINO JACK SOBOLEWSKI</b>				2. Date of Death Month <b>April</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>10:50 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien-Riverside Nursing &amp; Rehab. Center</b>				4b. City, Town, or Location of Death <b>Belcamp</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>152-30-3852</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 2, 1939</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>516 Newberry Court</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer Associate</b>		16b. Kind of Business/Industry <b>Phone Company</b>	
	17. Father's Name (First, Middle, Last) <b>Joseph Sobolewski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Santa DeSalvo</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Inez M. Sobolewski (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>516 Newberry Court, Joppa, Md. 21085</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Date <b>4/29/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory failure</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate interval Between Onset and Death <b>3 months</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>coronary vascular accident</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number <b>D28339</b>				29d. Date signed (Month, Day, Year) <b>April 26, 1996</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>101 E. Wheel Road Bel Air MD 21015</b>							
	31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 13002

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Andrew Schrueder Sr.</b>				2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>12:54 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>212-01-4522</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1916</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3100 Chesterfield Avenue</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Millworker &amp; Carpenter</b>		16b. Kind of Business/Industry <b>Lumber Business</b>				
17. Father's Name (First, Middle, Last) <b>Charles F. Schrueder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Marr</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mary M. Schrueder (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3100 Chesterfield Avenue, Baltimore, Maryland 21213</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>5-1-96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane, Baltimore, Maryland 21213</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Ventricular tachycardia</b> Due to (or as a consequence of):  b. <b>Myocardial infarction</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Paula Mary Rosenthal MD</b>		29c. License number <b>D31025</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Division of Geriatrics, 3333 N. Calvert St #325, Baltimore MD 21218</b>										
31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

DHMM 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

96 13003

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna M. Stevens</b>		2. Date of Death Month <b>April</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>4:38 AM</b>
	4a. Facility Name (If not Institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>043-24-8848</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 14, 1932</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2 Bethway Drive-Apt. 103-P.O. Box 98</b>		10f. Zip Code <b>21784</b>
	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>L.P.N.</b>		16b. Kind of Business/Industry <b>Medical</b>		17. Father's Name (First, Middle, Last) <b>Thomas Albert Minnock</b>
	18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Svec</b>		19a. Informant's Name/Relationship (Type, Print) <b>William Stevens/Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 98-Sykesville, Maryland 21784</b>
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>		22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary Embolism</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Renal failure</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>N. Moubaddem, M.D.</b>		29c. License number <b>D46358</b>	
29d. Date signed (Month, Day, Year) <b>April 27, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. Moubaddem, Carroll County Gen Hosp, Westminster, MD 21157</b>		31. Date filed (Month, Day, Year) <b>MAY 1, 1996</b>	
32. Registrar's Signature <b>J. Davidson-Randall</b>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>State Registrar</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at 902-8.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13004

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Vivian L. Smith

2. Date of Death

April 29, 1996 Year

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

East Point Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore Co.

5. Social Security Number

218-14-6996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 3, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

X ☒ Yes 2 ☐ No

10e. Street and Number

6610 Woods Parkway - Apt 1B

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Factory worker

16b. Kind of Business/Industry

manufacturing

17. Father's Name (First, Middle, Last)

Lawrence C. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Tull

19a. Informant's Name/Relationship (Type, Print)

G. Jean Middleton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6610 Woods Parkway Apt 1B, Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park 5/2/96 Elkridge, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*James B. Eline*

22. Name and Address of Facility

11824 Reisterstown Rd.  
Eline Funeral Home Reisterstown, MD 2113623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA WITH LEFT PLURAL EFFUSION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Dr. Martin D. C. Physician*

29c. License number

D 14618

29d. Date signed (Month, Day, Year)

April 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIENVENIDO R MATOS, M.D. 21 CRANBROOK RD. COKEYSVILLE, MD 21030

31. Date filed (Month, Day, Year)

MAY 2 1996

32. Registrar's Signature

*John Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible handwritten notes visible through the paper from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13005

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Raymon H. Strunk</b>				2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>9:15 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>417 S. Bentalou Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>City</b>	
5. Social Security Number <b>217-50-6066</b>		6. Sex <b>MM</b> <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-22-1934</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>City</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>417 S. Bentalou Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1955-1975</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>construction</b>		16b. Kind of Business/Industry <b>Presley Construction Co.</b>			
17. Father's Name (First, Middle, Last) <b>Walter Adams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Doris B. Strunk</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Bernadette Yanke freind</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>417 S. Bentalou St. Baltimore Md 21223</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Cedar Hill Cemetery</b>		Date <b>5-1-96</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McCully Funeral Home</b> <b>130 E. Fort Ave. Baltimore, Md. 21230</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>ATHEROSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number <b>036033</b>		29d. Date signed (Month, Day, Year) <b>4/28/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. Bercovitz MD 8028 Ritchie Highway Pasadena Md. 21122</b>							
31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>				32. Registrar's Signature <i>[Signature]</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13006

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lee Henry Timberlake</i>				2. Date of Death Month <i>April</i> Day <i>28</i> Year <i>1996</i>		3. Time of Death <i>1:10 PM</i>		
	4e. Facility Name (If not Institution, give street and number) <i>9428 Nicklaus Lane</i>				4b. City, Town, or Location of Death <i>Laurel</i>		4c. County of Death <i>Prince George</i>		
Funeral Director	5. Social Security Number <i>007-34-1618</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>57</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>June 12, 1938</i>	9. Birthplace (State or Foreign Country) <i>Maine</i>	
	Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>Prince George</i>		10c. City, Town or Location <i>Laurel</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>9428 Nicklaus Lane</i>				10f. Zip Code <i>20708</i>		10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Court Reporter/Editor</i>		16b. Kind of Business/Industry <i>Senate Daily Digest</i>			
17. Father's Name (First, Middle, Last) <i>Henry Timberlake</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Lou Abbot Timberlake</i>					
19e. Informant's Name/Relationship (Type, Print) <i>Charlotte Timberlake/Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9428 Nicklaus Lane, Laurel, Maryland 20708</i>					
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MD National Mem. Park</i>		Date <i>5/1</i>		20c. Location - City or Town, State <i>Laurel, Maryland</i>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</i>					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Acquired immunodeficiency syndrome</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Augusto P. Rodriguez MD</i>		29c. License number <i>221230</i>		29d. Date signed (Month, Day, Year) <i>April 28, 1996</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Ct. Sp. Md 20748</i>									
31. Date filed (Month, Day, Year) <i>MAY 2 1996</i>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Medical or Attending Physician: The law requires that the death certificate be executed with the physician's signature after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 3. PER DR. FILM G-735

State of Maryland / Department of Health and Mental Hygiene

96 13007

5/7/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLYDE T. TURNER				2. Date of Death Month Day Year APRIL 28, 1996		3. Time of Death 11:36 AM		
	4a. Facility Name (If not institution, give street and number) 817 FRANCIS AVENUE				4b. City, Town, or Location of Death RELAY		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 237-09-4925		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 17, 1913		
	9. Birthplace (State or Foreign Country) NORTH CAROLINA								
Usual Residence of Decedent									
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location RELAY			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 817 FRANCIS AVENUE					10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER			16b. Kind of Business/Industry TEXACO		
17. Father's Name (First, Middle, Last) EDGAR CRAIG TURNER				18. Mother's Name (First, Middle, Maiden Surname) JENNIE MEBANE					
19a. Informant's Name/Relationship (Type, Print) DORIS TURNER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 FRANCIS AVENUE - RELAY, MD 21227					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BAUST CHURCH CEMETERY		20c. Date 5/1/96		20d. Location - City or Town, State WESTMINSTER		
21. Signature of Funeral Service Licensee Jackie D. Shannon				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Multiinfarct Dementia</u> Due to (or as a consequence of): b. <u>Cerebrovascular accidents, multiple</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 2 yrs									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart Failure</u> <u>Non Insulin Dependent Diabetes Mellitus</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier J. William Cook		29c. License number D44243		29d. Date signed (Month, Day, Year) April 30, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. J. WILLIAM COOK, IV - 1311 FRANCIS AVENUE - ARBUTUS, MARYLAND 21227									
31. Date filed (Month, Day, Year) MAY 2 1996				32. Registrar's Signature J. William Cook					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

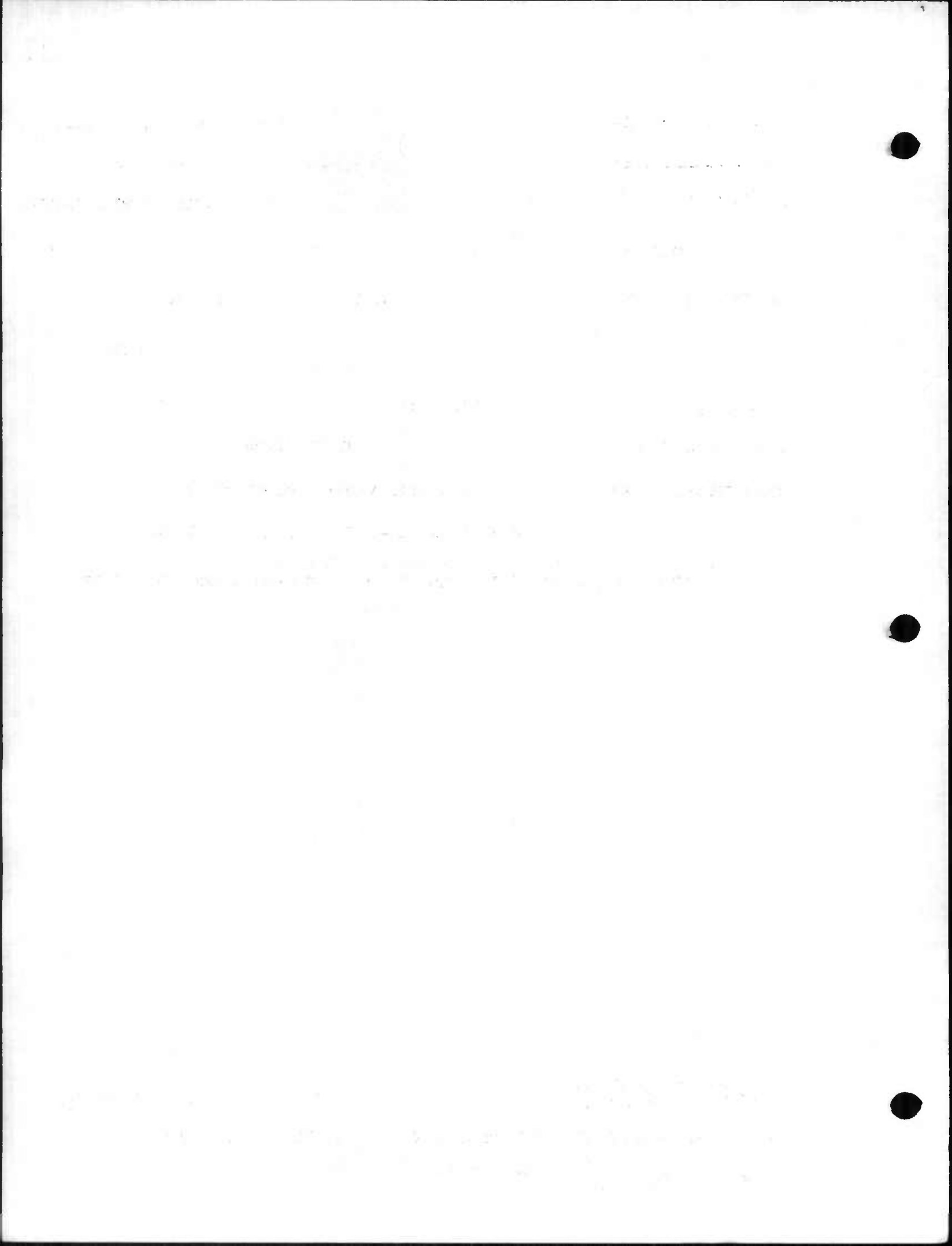
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

8+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13008

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MICHELE EVANSTILLET</b>						2. Date of Death Month Day Year <b>APRIL 29<sup>th</sup> 1996</b>		3. Time of Death <b>9:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOS</b>						4b. City, Town, or Location of Death <b>BALTO</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-70-4531</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>38</b>		8. Date of Birth (Month, Day, Year) <b>DEC 7, 1957</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTO</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>1147 DEANWOOD AVE</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERICAL WORKER</b>			16b. Kind of Business/Industry <b>UNIVERSITY</b>			
	17. Father's Name (First, Middle, Last) <b>WALTER EVANS</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>NOOMI HENDERSHATT</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ROBERT TILLET/HUSBAND</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1147 DEANWOOD AVE BALTO, MD 21234</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL</b>		Date <b>MAY 3, 1996</b>		20c. Location - City or Town, State <b>BALTO, MD</b>			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CARDIAC ARRHYTHMIAS</b> Due to (or as a consequence of): b. <b>AIDS CARDIOMYOPATHY</b> Due to (or as a consequence of): c. <b>HIV positivity</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>2 hrs</b> <b>&gt;5 yrs.</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MAI positive</b>									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier MD			
	29c. License number <b>P09305</b>						29d. Date signed (Month, Day, Year) <b>APRIL 29<sup>th</sup> 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUNAY P. PRADHAN, MD GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239.</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>						32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filed with the funeral director, page 2 should be detached for use as the burial-transit permit.




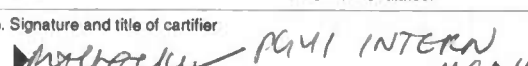

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13009

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SADIE L. TONTZ</b>		2. Date of Death Month Day Year <b>APRIL 28 1996</b>		3. Time of Death <b>1:00 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>219-20-8161</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>10/27/27</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>212 Washburn Ave.</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Banking</b>
	17. Father's Name (First, Middle, Last) <b>Frank Davis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Buck</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Gerald Miller / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>212 Washburn Ave. Baltimore, Maryland 21225</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery 5/1/96</b>		20c. Location - City or Town, State <b>Baltimore City</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McCully Funeral Home of Brooklyn 21225 237 E. Patapsco Ave. Baltimore, Md.</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ACUTE PULMONARY EDEMA</b> Due to (or as a consequence of): b. <b>STATUS POST CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): c. <b>CORONARY VASCULAR DISEASE</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  29c. License number <b>AS 2441614-19</b> 29d. Date signed (Month, Day, Year) <b>April 28, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BINU CHACKO 3001 SHANOVER STREET HARBOR HOSPITAL, BALTIMORE, MD</b>					
31. Date filed (Month, Day, Year) <b>MAY 2 1996</b> 32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13010

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEROY W. WIDMYER				2. Date of Death Month: APRIL Day: 27, Year: 1996		3. Time of Death 9:45 A.M.		
	4a. Facility Name (If not institution, give street and number) 1105 BAYARD STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY		
Funeral Director	5. Social Security Number 214-18-3862	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 11, 1922		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE CITY		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1105 BAYARD STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN		16b. Kind of Business/Industry ELECTRICIAL ENGINEER				
	17. Father's Name (First, Middle, Last) WILLIAM WIDMYER				18. Mother's Name (First, Middle, Maiden Surname) GRACE SHETTLE				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DOROTHY M. WIDMYER (SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 BAYARD STREET - BALTIMORE, MD 21223				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 4/30/96		20c. Location - City or Town, State BALTIMORE		
	21. Signature of Funeral Service Licensee <i>Jackie W. Shannon</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Coronary Heart Disease</u> Due to (or as a consequence of): b. <u>Rheumatoid Arthritis</u> Due to (or as a consequence of): c. <u>Rheumatoid Vasculitis</u> Due to (or as a consequence of): d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>A. Shams</i>		29c. License number D14798		29d. Date signed (Month, Day, Year) 4.29.96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. A. SHAMS - 716 MAIDEN CHOICE LANE - SUITE 301-CATONSVILLE, MD 21228									
31. Date filed (Month, Day, Year) MAY 02 1996		32. Registrar's Signature <i>Julie Taylor-Randall</i>							

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Desmond C. C. Warne				2. DATE OF DEATH MONTH DAY YEAR April 29 1996		3. TIME OF DEATH 1:51 A.M.	
4. SOCIAL SECURITY NUMBER 220-50-1931		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 67 YRS.	7. DATE OF BIRTH (Month, Day, Year) February 5, 1929		8. BIRTHPLACE (State or Foreign Country) England	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore, City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6624 Belford Road				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? England	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Industrial Mechanic		16b. KIND OF BUSINESS/INDUSTRY Self Employed			
17. FATHER'S NAME (First, Middle, Last) Charles Warne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Chandler			
19a. INFORMANT'S NAME (Type/Print) Mrs. Josephine M. Warne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corporation 5/2/96		20c. LOCATION — City or Town, State Towson, Maryland		20d. DATE 5/2/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald C. Schaffer</i>				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Alexander</i>				29c. LICENSE NUMBER D44560		29d. DATE SIGNED (Month, Day, Year) 4/29/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey Alexander, MD 660 Kenilworth Drive							
31. DATE FILED (Month, Day, Year) MAY 2 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13012

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen R. Wild</b>				2. Date of Death Month <b>April</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>5:55 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Charlestown Nursing Home</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>072 14 0136</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 18, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>715 Maiden Choice Lane</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>In own home</b>			
	17. Father's Name (First, Middle, Last) <b>James Bannon</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Ferrell</b>		19a. Informant's Name/Relationship (Type, Print) <b>Ann Tehan</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5845 Richardson Mews Sq. Baltimore, Maryland 21227</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20d. Date <b>5/2/96</b>	
	21. Signature of Funeral Service licensee 		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>		Approximate Interval Between Onset and Death <b>months</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D47447</b>		29d. Date signed (Month, Day, Year) <b>May 1, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Larris, 715 Maiden Choice Lane, Catonsville, MD</b>		31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

96 13013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thomas Raymond Wilson</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>				3. Time of Death <b>9:40pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>6138 Drumpoint Road</b>				4b. City, Town, or Location of Death <b>Deale</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>243-02-5301</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 20, 1911</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Deale</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>6138 Drumpoint Road</b>				10f. Zip Code <b>20751</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Antiques</b>				16b. Kind of Business/Industry <b>Antique Dealer</b>	
	17. Father's Name (First, Middle, Last) <b>Cebon Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Nunn</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lettie Wilson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6138 Drumpoint Road, Deale, MD 20751</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham, MD. Vets. Cem. 5/2 Cheltenham, MD</b>		20c. Location - City or Town, State			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Robert J. Smith</i>				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic myelocytic leukemia</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. peptic ulcer disease</b> <b>c. prostatic cancer</b> Due to (or as a consequence of):  Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death <b>6 mos.</b>	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Stuart E. Selonick, M.D.</i>				29c. License number <b>019838</b>	
	29d. Date signed (Month, Day, Year) <b>4/30/96</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart E. Selonick, M.D. 900 Bestgate Rd St 300 Annap., MD 21401</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 2 1996</b>				32. Registrar's Signature <i>John Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13014

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Washington

2. Date of Death

Month  
4Day  
30Year  
96

3. Time of Death

333 AM

4a. Facility Name (If not institution, give street and number)

818 N. Collington Ave.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

214-82-3178

6. Sex

F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12 30 59

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

818 N. Collington Ave

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Guard

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Clarke Smith

18. Mother's Name (First, Middle, Maiden Surname)

Irene Washington

19a. Informant's Name/Relationship (Type, Print)

Patricia Washington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4013 W Franklin St Baltimore MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cem.

Date

5-2-96 Baltimore, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylie FH PA

638 N. Gilman St.

21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

END STAGE AIDS CD4 4 June 1995 4 YEARS

Due to (or as a consequence of):

b.

CHRONIC DIARRHOEA

4 Mths

Due to (or as a consequence of):

c.

ANEMIA

1 YEAR

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mamathas Ananth

29c. License number

PGY, RESIDENT PO 8417.

29d. Date signed (Month, Day, Year)

MAY 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAMATHAS ANANTH. 900 CATON AVE, ST AGNES HOSPITAL, BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

MAY 2 1996

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13015

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>CAROLYN MARIE YOUNG</u>				2. Date of Death Month <u>04</u> Day <u>29</u> Year <u>96</u>		3. Time of Death <u>17.00h</u>		
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>		
Funeral Director	5. Social Security Number <u>217-20-8853</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>70</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Nov. 29, 1925</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent								
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Dundalk</u>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number <u>7912 St. Bridget Lane</u>				10f. Zip Code <u>21222</u>		10g. Citizen of What Country? <u>United States</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10 years</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Own Home</u>			
17. Father's Name (First, Middle, Last) <u>Earl Joseph Whitely</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Marie Usklander</u>				
19a. Informant's Name/Relationship (Type, Print) <u>David R. Young (Son)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7919 C Trappe Road Dundalk, Maryland 21222</u>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Oak Lawn Cemetery</u>		Date <u>5/3/96</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>END-STAGE CARDIOMYOPATHY</u> 6 weeks Due to (or as a consequence of): b. <u>MYOCARDIAL INFARCTION</u> 6 weeks Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SEPSIS</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>95012</u>		29d. Date signed (Month, Day, Year) <u>04/29/96</u>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>DR. KULBIR SANDHU - JOHNS HOPKINS BAYVIEW MEDICAL CENTER</u>						31. Date filed (Month, Day, Year) <u>MAY 2 1996</u>			
32. Registrar's Signature <u>[Signature]</u>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13016

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED MARTHA ANDERSON</b>				2. Date of Death Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>3:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>528- ROBINSON ST</b>				4b. City, Town, or Location of Death <b>BELAIR</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>215-74-9043</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 16, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>BELAIR</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>528 ROBINSON ST</b>		10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE</b>		16b. Kind of Business/Industry <b>HOSPITAL</b>			
	17. Father's Name (First, Middle, Last) <b>THOMAS CONROY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Letitia Dando</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary L. McDonough / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>518 ROBINSON ST. BELAIR MD. 21014</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. IGNATIUS CEMETERY</b>		20c. Location - City or Town, State <b>APRIL 30, 1996 HICKORY, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL BELAIR 3 NEWPORT DR. FOREST HILL MD. 21050</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ADENOCARCINOMA, LEFT LUNG</b> Probably Due to (or as a consequence of): <b>METASTATIC TO BONES</b> Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>DD 8791</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. BEN OTEYZA 846 S. Main St. Bel Air, Md.</b>							
	31. Date filed (Month, Day, Year) <b>MAY 3 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13017

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FANNIE AUGUSTUS</b>				2. Date of Death Month Day Year <b>APRIL 26, 1996</b>		3. Time of Death <b>1:45 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTO. CITY</b>	
Funeral Director	5. Social Security Number <b>UNKNOWN</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11-18-1908</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BALTO. CITY</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3336 PIEDMONT AVE.</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFR. AMERICAN</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNKNOWN</b>		16b. Kind of Business/Industry <b>UNKNOWN</b>		
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>REV. JEREMIAH WILLIAMS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1211 W. LANVALE STREET BALTO. MD 21217</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEM.</b>		Date <b>5/1/1996</b>		20c. Location - City or Town, State <b>CATONSVILLE MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD 21217</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal failure</b> Due to (or as a consequence of): <b>b. coronary artery disease</b> Due to (or as a consequence of): <b>c. metabolic acidosis</b> Due to (or as a consequence of): <b>d. Chronic anemia</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardio-pulmonary arrest.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Attending Phys</b>						
29c. License number <b>D30115</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. OHIOKPEHAI, MD 2600 LIBERTY HILLS AVE BALTO, MD 21215</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

1. The first part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation

$$f(x) = \int_0^x f(t) dt + \int_0^x f(t) dt + \int_0^x f(t) dt + \dots$$

$$f(x) = \int_0^x f(t) dt + \int_0^x f(t) dt + \int_0^x f(t) dt + \dots$$

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$$f(x) = \int_0^x f(t) dt + \int_0^x f(t) dt + \int_0^x f(t) dt + \dots$$



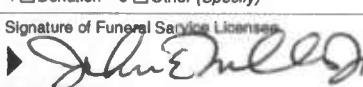
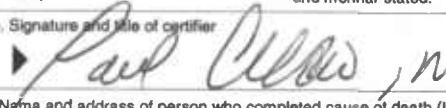
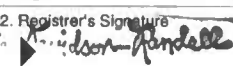
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13018

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SOPHIE ATHAS</b>				2. Date of Death Month Day Year <b>APRIL 30 1996</b>		3. Time of Death <b>10:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2916 HILLCREST AVE.</b>				4b. City, Town, or Location of Death <b>PARKVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-24-9202</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 3, 1926</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>PARKVILLE</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2916 HILLCREST</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6YRS</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OFFICE CLERK</b>			16b. Kind of Business/Industry <b>MARYLAND NATIONAL</b>		
	17. Father's Name (First, Middle, Last) <b>PETER ATHAS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>PAULINE PANOS</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>GEORGIA ATHAS</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2916 HILLCREST AVE. PARKVILLE 21234</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEK ORTHODOX CEM.</b>		Date <b>5/3</b>		20c. Location - City or Town, State <b>WOODLAWN</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. 21234</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>4 months</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D30529</b>		29d. Date signed (Month, Day, Year) <b>5/1/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. PAUL CELANO #205 6569 N Charles St, BALTIMORE 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the paper  
is devoted to a general  
discussion of the problem.

2. In the second part  
we shall consider the  
case of a specific example.

3. The third part of the paper  
is devoted to a detailed  
analysis of the results.

4. In the fourth part  
we shall discuss the  
conclusions of the paper.

5. The fifth part of the paper  
is devoted to a general  
discussion of the problem.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13019

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div align="center" style="font-size: 1.2em;">Janie Pearl Alexander</div>					2. Date of Death Month <u>April</u> Day <u>26</u> Year <u>1996</u>		3. Time of Death <div align="center" style="font-size: 1.2em;">5:15A</div>			
	4a. Facility Name (If not institution, give street and number) <div align="center" style="font-size: 1.2em;">Doctors Hospital</div>					4b. City, Town, or Location of Death <div align="center" style="font-size: 1.2em;">Lanham, MD</div>		4c. County of Death <div align="center" style="font-size: 1.2em;">Prince George</div>			
<b>Funeral Director</b>	5. Social Security Number <div align="center" style="font-size: 1.2em;">579-28-9439</div>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <div align="center" style="font-size: 1.2em;">85</div> Yrs.		8. Date of Birth (Month, Day, Year) <div align="center" style="font-size: 1.2em;">March 11, 1911</div>		9. Birthplace (State or Foreign Country) <div align="center" style="font-size: 1.2em;">S.C.</div>		
	Usual Residence of Decedent										
10a. State <div align="center" style="font-size: 1.2em;">MD.</div>			10b. County <div align="center" style="font-size: 1.2em;">Prince George</div>			10c. City, Town or Location <div align="center" style="font-size: 1.2em;">Lanham</div>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <div align="center" style="font-size: 1.2em;">5809 Lundy Drive</div>					10f. Zip Code <div align="center" style="font-size: 1.2em;">20706</div>		10g. Citizen of What Country? <div align="center" style="font-size: 1.2em;">U.S.</div>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <div align="center" style="font-size: 1.2em;">Black</div>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <div align="center" style="font-size: 1.2em;">12th Grade</div> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <div align="center" style="font-size: 1.2em;">Food Services Industry</div>			16b. Kind of Business/Industry <div align="center" style="font-size: 1.2em;">Hilton Hotel</div>			
17. Father's Name (First, Middle, Last) <div align="center" style="font-size: 1.2em;">William Byrd</div>						18. Mother's Name (First, Middle, Maiden Surname) <div align="center" style="font-size: 1.2em;">Rosa Lee Griffin</div>					
19a. Informant's Name/Relationship (Type, Print) <div align="center" style="font-size: 1.2em;">Addie A. Allen</div>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div align="center" style="font-size: 1.2em;">5809 Lundy Dr., Lanham, MD 20706</div>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <div align="center" style="font-size: 1.2em;">Harmony Memorial Park</div>		Date <div align="center" style="font-size: 1.2em;">5-1-96</div>		20c. Location - City or Town, State <div align="center" style="font-size: 1.2em;">Suitland, MD</div>			
21. Signature of Funeral Service Licensee <div align="center" style="font-size: 1.5em;">Shelton W. Hackett</div>					22. Name and Address of Facility <div align="center" style="font-size: 1.2em;">Tri-State Funeral Services, Inc. 6234 3rd St., N.W., Wash. D.C. 20011</div>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div align="center" style="font-size: 1.5em;">RESPIRATORY FAILURE</div> Due to (or as a consequence of): <div align="center" style="font-size: 1.5em;">ENCEPHALOPATHY — COMA.</div> Due to (or as a consequence of): <div align="center" style="font-size: 1.5em;">STROKE</div> Due to (or as a consequence of): <div align="center" style="font-size: 1.5em;">MI; CAD; HTN; CHF</div> <div align="center" style="font-size: 1.5em;">G.I. bleed.</div>										Approximate Interval Between Onset and Death <div align="center" style="font-size: 1.5em;">&gt; 10 days</div>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <div align="center" style="font-size: 1.2em;">M</div>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <div align="center" style="font-size: 1.5em;">[Signature]</div>	
					29c. License number <div align="center" style="font-size: 1.5em;">D-34525</div>		29d. Date signed (Month, Day, Year) <div align="center" style="font-size: 1.5em;">04-26-96</div>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <div align="center" style="font-size: 1.2em;">S.J. Rao, MD - 4000 Mitchellville Road; #220, Bowie MD - 20716.</div>											
31. Date filed (Month, Day, Year) <div align="center" style="font-size: 1.5em;">MAY 03 1996</div>					32. Registrar's Signature <div align="center" style="font-size: 1.5em;">[Signature]</div>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Item: 1, per F.H. 6-735 5/6/96 reb

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard <del>Wilson</del> Bradley		2. Date of Death Month Day Year April 29, 1996		3. Time of Death 6:30 P.M.
	4a. Facility Name (If not institution, give street and number) 4205 Springwood Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 320-16-1814	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 17, 1915	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4205 Springwood Avenue		10f. Zip Code 21206		10g. Citizen of What Country? United States
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman / Manager		16b. Kind of Business/Industry Department Store
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edward Turner Bradley		18. Mother's Name (First, Middle, Maiden Surname) Lillian May Hanson		
	19a. Informant's Name/Relationship (Type, Print) Emma Naomi Bradley / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4205 Springwood Avenue, Baltimore, Maryland-21206		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee Kathleen M. Murphy		22. Name and Address of Facility 6415 Belair Road John C. Miller, Inc. Baltimore, Maryland-21206		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. Chronic obstructive pulmonary disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 month 10 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Coronary artery disease				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Stewart R. Willis MD.		
	29c. License number D36663		29d. Date signed (Month, Day, Year) 05/01/96		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stewart R. Willis MD, Good Samaritan Hospital, Baltimore, MD.				
	31. Date filed (Month, Day, Year) MAY 03 1996				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10 + 1



FILM G-735 5/28/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRIAN S BABOOLAL			2. Date of Death Month Day Year APRIL 29, 1996		3. Time of Death 1254PM		
	4e. Facility Name (If not institution, give street and number) SINAI HOSPITAL I.C.U.			4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A		
Funeral Director	5. Social Security Number 090-70-2686		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 16 Yrs.		8. Date of Birth (Month, Day, Year) June 6, 1979	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodlawn	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4 McLendon Ct.		10f. Zip Code 21244		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <del>Yes</del> No Specify: <u>Jamaican</u>		14. Race - American Indian, Black, White, etc. Specify: <u>INDIAN</u> <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry High School				
17. Father's Name (First, Middle, Last) Solomon Baboolal		18. Mother's Name (First, Middle, Maiden Summa) Mavis Callender		19a. Informant's Name/Relationship (Type, Print) Mavis C. Baboolal (Mother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 McLendon Ct. Baltimore, MD 21244		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc.		20c. Location - City or Town, State 5-4-96 Hampstead, Maryland				
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Gunshot wounds of head</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 4-28-96		
28b. Time of Injury 1712 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) REAR YARD		
28f. Location (Street and Number or Rural Route Number, City or Town, State) 4015 Garrison Ave		29a. Certify (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		
29d. Date signed (Month, Day, Year) APRIL 30, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Kewlocke, MD		31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature <i>[Signature]</i>		
33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

File: 100-44-2000-1

Re: JAMES EARL RAY

Page 1

TO: DIRECTOR, FBI

FROM: SAC, MEMPHIS

SUBJECT: MURDER OF MARTIN LUTHER KING, JR.

RE: MEMPHIS TELETYPE TO BUREAU, APRIL 4, 1968.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM contains information regarding the activities of the Memphis Police Department (MPD) in connection with the investigation of the assassination of Dr. King.

The LHM also contains information regarding the activities of the Memphis Police Department (MPD) in connection with the investigation of the assassination of Dr. King.

Very truly yours,

W. J. RAY

Enclosure

*[Handwritten signature]*

W. J. RAY

cc

TO: DIRECTOR, FBI

FROM: SAC, MEMPHIS

100-44-2000-1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13022

## Certificate of Death

Reg. No.


Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Melvin A Bettis</u>				2. Date of Death Month <u>April</u> Day <u>27</u> Year <u>1996</u>		3. Time of Death <u>1659</u>	
	4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>216 21 9136</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>7</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>6/25/88</u>	
	10a. State <u>MD.</u>		10b. County <u>BALTO. CITY</u>		10c. City, Town or Location <u>BALTIMORE</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <u>2833 Waldorf AVE</u>				10f. Zip Code <u>21215</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>student</u>		16b. Kind of Business/Industry <u>BALTO. CITY SCHOOL</u>	
	17. Father's Name (First, Middle, Last) <u>SHELDON WALKER</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>LEISHA BETTIS</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>LEISHA BETTIS</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2833 WALDORF AVE, BALTO. CITY 21215</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>WOODLAWN PARK</u>		20c. Location - City or Town, State <u>BALTIMORE, MD.</u>		20d. Date <u>5/2/96</u>	
	21. Signature of Funeral Service Licensee <u>Leah A. Esler</u>				22. Name and Address of Facility <u>ESTEP BROTHERS FUNERAL HOME P.A.</u> <u>1300 EUTAW PL. BALTO. MD. 21217</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>MULTIPLE INJURIES</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5. <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u>4-27-96</u>		28b. Time of Injury <u>1635P M</u>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>VEHICLE PEDESTRIAN STRUCK BY POLICE</u>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <u>4600 BLK REISTERSTOWN RD BALTIMORE MD</u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>4600 BLK REISTERSTOWN RD BALTIMORE MD</u>	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <u>Marjorie Oneill</u>				29c. License number <u>O.C.M.E</u>		29d. Date signed (Month, Day, Year) <u>APRIL 28, 1996</u>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MARYMARTIN D. KOSKOWSKI 111 PENNS ST BALTIMORE MARYLAND</u>							
	31. Date filed (Month, Day, Year) <u>MAY 03 1996</u>				32. Registrar's Signature <u>J. Davidson</u>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene **96 13023**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES EDWARD BOTTERILL</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>12:25 PM</b>													
	4e. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson, Maryland</b>		4c. County of Death <b>Baltimore</b>													
Funeral Director	5. Social Security Number <b>220-24-8362A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 20, 1930</b>													
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>													
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
	10e. Street and Number <b>305 E. Joppa Rd. Apt. 1306</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operating Engineer</b>		16b. Kind of Business/Industry <b>Local 37</b>													
	17. Father's Name (First, Middle, Last) <b>Elmer Botterill</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Frey</b>															
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Robert Botterill (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>647 Bulk Plant Rd. Littlestown, PA 17340</b>															
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation, Inc.</b>		20c. Location - City or Town, State <b>5-1-96 Hampstead, Maryland</b>															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</b>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>ACUTE MYOCARDIAL INFARCTION</b></td> <td><b>HOURS</b></td> </tr> <tr> <td>b.</td> <td><b>CORONARY ARTERY DISEASE</b></td> <td><b>YEARS</b></td> </tr> <tr> <td>c.</td> <td><b>RESPIRATORY FAILURE</b></td> <td><b>HOURS</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	<b>HOURS</b>	b.	<b>CORONARY ARTERY DISEASE</b>	<b>YEARS</b>	c.	<b>RESPIRATORY FAILURE</b>	<b>HOURS</b>	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	<b>HOURS</b>																	
	b.	<b>CORONARY ARTERY DISEASE</b>	<b>YEARS</b>																	
	c.	<b>RESPIRATORY FAILURE</b>	<b>HOURS</b>																	
	d.																			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					

29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 		29c. License number <b>D 31826</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1996</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>RICHARD L. LINTHICUM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

3024

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Jean Butler

2. Date of Death

Month 04 Day 06 Year 1996

3. Time of Death

7:20AM

4a. Facility Name (If not Institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

unknown Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

unknown

9. Birthplace (State or Foreign Country)

Wash.D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

918 Pennsylvania Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Norris Williams Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

930 47th PL.N.E. Wash. D.C. 20019

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Northern Va. Crematory 4/10/96 Arlington, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janice Edwards

22. Name and Address of Facility

Hodges and Edwards  
3910 Silver Hill RD. Suitland, MD. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

Sepsis

Due to (or as a consequence of):

Renal Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cachexia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Syed Haque

29c. License number

89249

29d. Date signed (Month, Day, Year)

April 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Haque, MD c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

MAY 03 1996

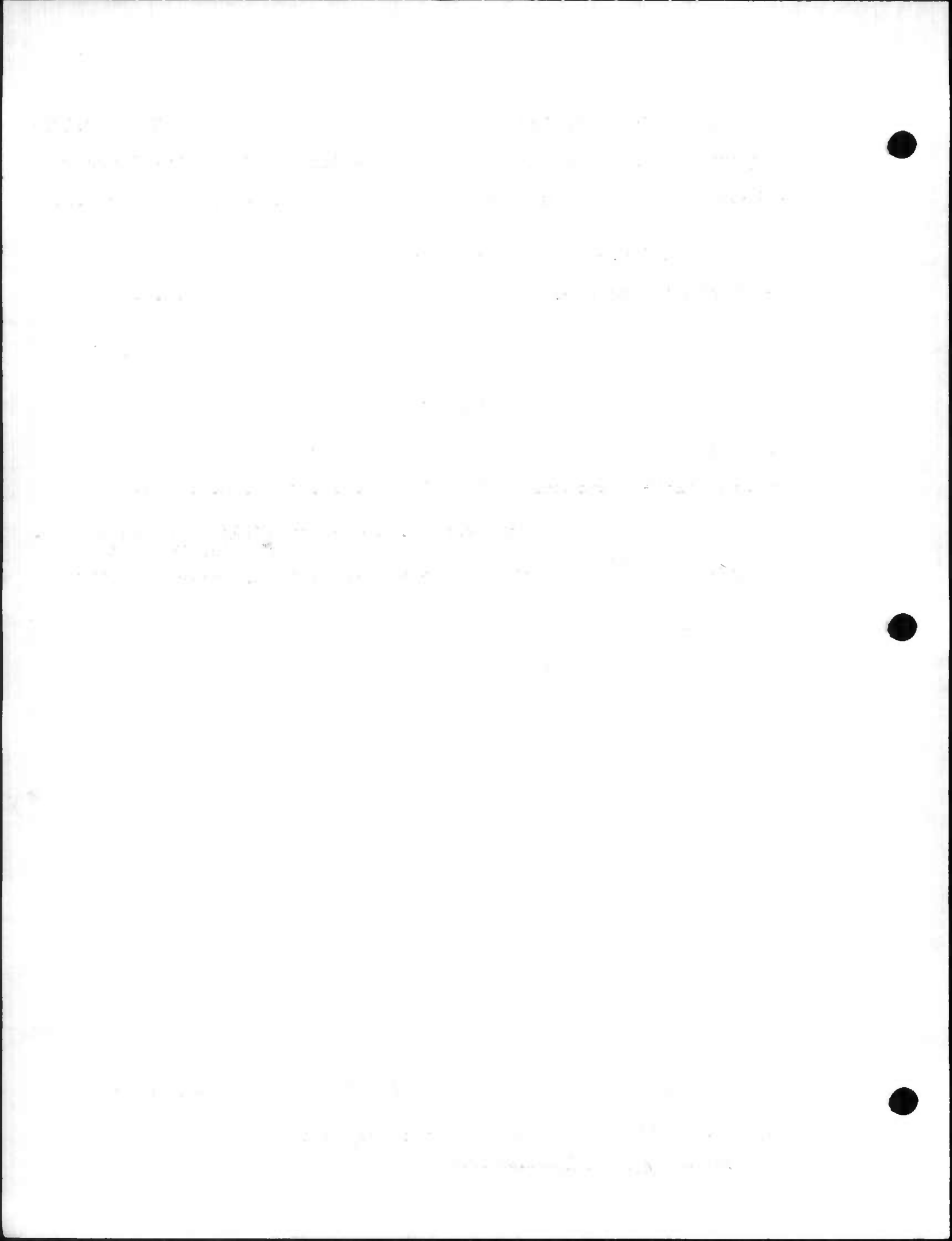
32. Registrar's Signature  
John A. RussellState  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



96 13025

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Daniel Charles Brewer, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27, 1996</b>		3. TIME OF DEATH <b>(2:00 P.M.)</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-9886</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 9, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>334 W. 29th Street</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Hardwood Floor Layer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William E. Brewer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Cooper</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arcadia Brewer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>334 W. 29th Street, Baltimore, Maryland 21211</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery 5/1 Garrison Forest, Maryland</b>		20c. LOCATION — City or Town, State <b>Burgee-Henss Funeral Home 21211</b>		20d. LOCATION — City or Town, State <b>3631 Falls Road, Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lynn Burgee Henss</b>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASYSTOLE</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>STROKE</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate interval between Onset and Death <b>15 MIN</b>							
Approximate interval between Onset and Death <b>1 DAY</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul A. RASSAM, MD</b>				29c. LICENSE NUMBER <b>A2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 27, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL RASSAM - 3223 St. Paul St - Baltimore, MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

56 13026

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Anna Josephine Brendel</b>				2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>6:47 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care- Towson</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>	
<b>Funeral Director</b>	5. Social Security Number <b>216-32-4519</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 4, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>509 East Joppa Road</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Unknown Weisinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martina Unknown Spitznagel</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary Frances Cardinale /Attorney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 N. Charles St-Suite 710, Baltimore, MD.-21201</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Data <b>5-4-96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller, Inc. Baltimore, Maryland-21206</b> 6415 Belair Road				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Metastatic lungs lymphoma</b> Due to (or as a consequence of):</p> <p>b. <b>ASCVD</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: right;"> <p>Approximate Interval Between Onset and Death</p> <p><b>34 years</b></p> <p><b>10 years</b></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D42736</b>		29d. Date signed (Month, Day, Year) <b>5-2-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7600 Oslar Drive Towson</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13027

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jerome Campbell</b>				2. Date of Death Month <b>05</b> Day <b>02</b> Year <b>1996</b>		3. Time of Death <b>8:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bon Secour Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>245-88-3235</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jun. 24, 1953</b>	9. Birthplace (State or Foreign Country) <b>N. Carolina</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>716 Washington Place</b>			10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>/</b> College (1-4or 5+) <b>2yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse Assistant</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Pete Campbell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Violene Manning</b>			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Violene Campbell</b>			19b. Mailing Address <b>1419 N. Bond Street</b> <b>1419 Bond Street, Baltimore, MD 21213</b>				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rockfish Memorial Park</b>		Date <b>5-5-96</b>	20c. Location - City or Town, State <b>Fayetteville, N.C.</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Baltimore, MD 21202</b>				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of): <b>Acquired Immune Deficiency 5 yrs</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>1 wk</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Christie Lamping MD</b>		29c. License number <b>D3 2263</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>		
30. Name and address of person who completed cause of death (Item 21e) (Type, Print) <b>C LAMPING 2000 W BALTIMORE ST 21223</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13028

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sarah Collins</i>				2. Date of Death Month <i>May</i> Day <i>2</i> Year <i>1996</i>		3. Time of Death <i>3:45 am</i>		
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital</i>				4b. City, Town, or Location of Death <i>Balto</i>		4c. County of Death <i>NIA</i>		
Funeral Director	5. Social Security Number <i>230-72-2349</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>46</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 14, 1949</i>	9. Birthplace (State or Foreign Country) <i>VA</i>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <i>md</i>		10b. County <i>NIA</i>		10c. City, Town or Location <i>Balto</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number <i>3532 Virginia Ave</i>				10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U.S.A</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12+</i> College (1-4 or 5+) <i>4 yrs</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i>		16b. Kind of Business/Industry <i>Balto Public School</i>				
	17. Father's Name (First, Middle, Last) <i>Robert Hemphill</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hazel Southerlin</i>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Maurice Collins - Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3532 Virginia Ave Balto, md 21215</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>md Natinal Mem Pk</i>		20c. Location - City or Town, State <i>Laurel, md</i>		20d. Date <i>5/6/96</i>		
	21. Signature of Funeral Service Licensee <i>Thorne A. Thompson Jr</i>				22. Name and Address of Facility <i>March A.H. West 4300 Wabash Ave</i>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Pneumonia</i> Due to (or as a consequence of):  b. <i>Non Small Cell Lung Cancer</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							Approximate Interval Between Onset and Death <i>4 days</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Antonio V. Aragon II MD</i>		29c. License number <i>15-2402321-AA-9910</i>		29d. Date signed (Month, Day, Year) <i>May 2, 1996</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Antonio V. Aragon II MD Sinai Hospital of Baltimore Baltimore MD 21215</i>									
31. Date filed (Month, Day, Year) <i>MAY 03 1996</i>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13029

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THERESA MARGAURITE CONNOR</b>				2. Date of Death Month Day Year <b>APRIL 28, 1996</b>		3. Time of Death <b>9:50 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1306 PUTTY HILL AVENUE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-05-3313</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>5/14/21</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TOWSON</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1306 PUTTY HILL AVENUE</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th GRADE</b> College (1-4or 5+) <b>COLLEGE</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>SHANE McSHANE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE DEMPSEY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARIE T. CONNOR DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1306 PUTTY HILL AVENUE TOWSON, MD 21286</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Data <b>5/1/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>METASTATIC CARCINOMA OF UNDETERMINED TYPE 1 YR</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D09386</b>		29d. Date signed (Month, Day, Year) <b>04-30-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Samuel I. O'Mansky, M.D. 8405 Loch Raven Blvd. #A Baltimore, MD 21286-8196</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13030

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROLAND M DUNNOCK</b>				2. Date of Death Month <b>4</b> Day <b>30</b> Year <b>96</b>		3. Time of Death <b>6:10 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Veterans Affairs Medical Center</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTO. CITY</b>	
Funeral Director	5. Social Security Number <b>218-56-0022</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7-1-1951</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>BALTO. CITY</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4815 REISTERTOWN ROAD</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1972 1974</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFR. AMERICAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEDICAL TECH.</b>		16b. Kind of Business/Industry <b>UNIVERSITY HOSPITAL</b>		17. Father's Name (First, Middle, Last) <b>ROLAND DUNNOCK</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>HENRIETTA VENTON DUNNOCK</b>		19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA DUNNOCK (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4815 REISTERTOWN ROAD BALTO. MD 21215</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST CEM.</b>		20c. Date <b>5/3/1996</b>		20d. Location - City or Town, State <b>OWINGSMILL MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD 21217</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> Due to (or as a consequence of): <b>Acquired Immune Deficiency Syndrome</b> Due to (or as a consequence of): <b>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b>		Approximate Interval Between Onset and Death <b>10 days</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input checked="" type="checkbox"/> No	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Deborah A. Som M.D.</b>		29c. License number <b>I 0818</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Deborah A. Som 22 S. Greene Street Baltimore, Maryland</b>		31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 		33. Registrar's Name <b>John A. Som</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death. The Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13031

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Yasukiyo Daitoku

2. Date of Death

April 30, 1996

3. Time of Death

9:34 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

547-20-7791

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 26, 1910

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

280 Lyons Watch Dr.

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming Strawberry

17. Father's Name (First, Middle, Last)

Nakazo

Daitoku

18. Mother's Name (First, Middle, Maiden Surname)

UNK

Oshita

19a. Informant's Name/Relationship (Type, Print)

Mary Daitoku /Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

280 Lyons Watch Dr. Pasadena, Md. 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc, 5/2/96 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home PA  
3111 Mountain Rd. Pasadena, Md 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary disease

Approximate interval between Onset and Death

3 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia (senile)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR OCHANEY MD

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

May 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR OCHANEY  
7845 OAKWOOD ROAD SUITE 205 GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13032

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

LENTION

DAWSON

2. Date of Death

April

Day

30

Year

1996

3. Time of Death

9:15 pm

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

257-24-9147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 5 1925

9. Birthplace (State or Foreign Country)

FLORIDA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2331 Aiken Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Maryland Dry Dock

17. Father's Name (First, Middle, Last)

LENNON DAWSON

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE GILLYARD

19a. Informant's Name/Relationship (Type, Print)

Mary Stokes/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2331 Aiken Street, Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERAN

Date

5-6-96

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic squamous cell carcinoma

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic squamous cell carcinoma to brain, lung, liver

5 months

c. Diabetes, Congestive Heart Failure, Emphysema, Hypertension

&gt; 1 year

&gt; 1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37695

29d. Date signed (Month, Day, Year)

5/2/96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

JOHN W. AMES, MD Dept. of Radiation Oncology, UNIV of Md Hospital  
22 South Greene St. Baltimore Md 21201

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13033

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Vera Mable Dickson</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>1:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Allegis Health and Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>024-26-7071</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1916</b>	9. Birthplace (State or Foreign Country) <b>Canada</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rosedale</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>9108 Abigail Drive Apt. 2"D"</b>				10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembler</b>		16b. Kind of Business/Industry <b>Electronics</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Thomas W. Dickson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etta L. Chennel</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth Scott (SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9108 Abigail Drive Apt. 2"D" Rosedale, Md. 21237</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens Of Faith Cemetery</b>		Date <b>5/4/1996</b>		20c. Location - City or Town, State <b>Baltimore Co., Md.</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Kruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Ovarian Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D22409</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph D. Antonio, LMD, 7401 Osler Drive Suite 201 Towson, Md. 21204</b>							
	31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <i>[Signature]</i>			





96 13034

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DESIRE M. ENY</b>						2. Date of Death Month Day Year <b>APRIL 29 1996</b>		3. Time of Death <b>11<sup>52</sup> AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1030 HOLLINGSWORTH Rd</b>						4b. City, Town, or Location of Death <b>JOPPA</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>285-18-0312</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 8, 1915</b>		9. Birthplace (State or Foreign Country) <b>France</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>JOPPA</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1030 HOLLINGSWORTH Rd</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CONSULTANT</b>			16b. Kind of Business/Industry <b>BioChemist</b>		
	17. Father's Name (First, Middle, Last) <b>Albert ENY</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>LÉONIE STORA</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>HENRIETTE ENY / SPOUSE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1030 HOLLINGSWORTH Rd. JOPPA MD 21085</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>			Date <b>MAY 4 1996</b>		20c. Location - City or Town, State <b>Balto. Md</b>	
	21. Signature of Funeral Service Licensee <i>Robert L. Graves</i>				22. Name and Address of Facility <b>EVANS CHAPEL c/o Bel Air 3 NEWPORT Forest Hill, MD. 21050</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiomyopathy</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): c. <b>Diabetes Mellitus</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>years</b> <b>years</b> <b>years</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Insufficiency</b> <b>Renal Insufficiency</b> <b>Atrial Fibrillation</b> <b>POSSIBLE CLOSED HEAD INJURY</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) <b>APR. 28 &amp; 29, 1996</b>										
28b. Time of Injury <b>UNKNOWN</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred <b>SUBJECT FELL</b>										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>										
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1030 HOLLINGSWORTH RD. JOPPA, MD.</b>										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Kermit P. Bonavitch MD</b>										
29c. License number <b>D05593</b>										
29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. Kermit Bonavitch 754 N. HICKORY AVE. BELAIR MD. 21014</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>										
32. Registrar's Signature <i>Julia Davidson-Randall</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13035

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT</b>				2. Date of Death Month <b>April</b> Day <b>27</b> Year <b>1996</b>				3. Time of Death <b>1:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>				4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>078 28 7294</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 5, 1910</b>		9. Birthplace (State or Foreign Country) <b>Poland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>		
10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>6121 Montrose Road</b>		10f. Zip Code <b>20852</b>	
10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>				15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>Collega (1-4or 5+)</b> <b>-7th-</b>			
16. Kind of Business/Industry <b>Glass Gift Store</b>				17. Father's Name (First, Middle, Last) <b>Jacob Einheber</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Miriam Thorn</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jack Einheber/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>895 West End Ave. #3C New York, NY 10025</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Mem. Gdns.</b>				20c. Date <b>1996</b>				20d. Location - City or Town, State <b>Falls Church, Va.</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>IVES-PEARSON FUNERAL HOMES 22046</b> <b>472 N. Washington St. Falls Church, Va.</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal failure</b> <b>Cardiac arrest</b> <b>Constrictive cardiomyopathy</b>			
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Parkinson's disease, decubitus ulcers</b> <b>Diabetes mellitus.</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>			
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Alan S. Chavaler MD</b>			
29c. License number <b>29453</b>				29d. Date signed (Month, Day, Year) <b>April 27 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type/Print) <b>15225 Shady Grove Rd Rockville MD 20850</b> <b>ALAN S. CHAVALER</b>			
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Carville Fowler				2. Date of Death Month Day Year April 30 1996		3. Time of Death 1:15 PM	
	4a. Facility Name (If not institution, give street and number) 7117 Wardman Rd.				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-05-7632-A		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) November 20, 1920	
	9. Birthplace (State or Foreign Country) Panama		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7117 Wardman Rd.		10f. Zip Code 21212		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dental Technician		16b. Kind of Business/Industry Dentistry		17. Father's Name (First, Middle, Last) John Carville Fowler	
	18. Mother's Name (First, Middle, Maiden Surname) Anna Brennan		19a. Informant's Name/Relationship (Type, Print) Jean Elizabeth Fowler/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7117 Wardman Rd. Baltimore, MD 21212		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Baltimore		21. Signature of Funeral Service Licensee John O. Mitchell IV		22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Cerebrovascular accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Timothy Hestibay, M.D.		29c. License number D32639		29d. Date signed (Month, Day, Year) 5/1/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy Hestibay MD 6600 Kenilworth Drive Ste 202 Towson, MD 21204		31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature John Davidson-Randall			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13037

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Ira FEHLE</b>				2. Date of Death Month <b>May</b> Day <b>01</b> Year <b>1996</b>		3. Time of Death <b>705PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-03-3782</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 16, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Idaho</b>		10e. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>United States</b>		
10e. Street and Number <b>3505 Keck Ave.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Federal Officer</b>		16b. Kind of Business/Industry <b>Social Security</b>		
17. Father's Name (First, Middle, Last) <b>John Fehle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Blanch</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Helen R. Fehle Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 Keck Ave. Randallstown, MD 21133</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		20c. Date <b>5/3/96</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee <b>Jane B. Corey</b>				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Randallstown, MD 21133</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Ischemic Cardiomyopathy</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes Mellitus Type 2</b> <b>Chronic Renal Failure</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>5 years</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus Type 2</b> <b>Chronic Renal Failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John Hunter Copeland MD</b>		29c. License number <b>D27034</b>		29d. Date signed (Month, Day, Year) <b>May 01, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Hunter Copeland MD 5310 Old Court Road Suite 200 Randallstown MD 21133</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>Julia Pearson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





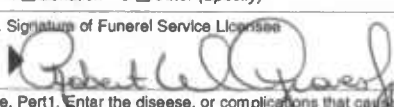
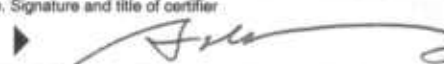
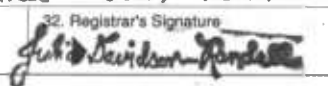
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13038

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roy A. Ford Sr.</b>				2. Date of Death Month Day Year <b>APRIL 27 1996</b>		3. Time of Death <b>11:30 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>13510 Blenheim Rd.</b>				4b. City, Town, or Location of Death <b>PHOENIX</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220-01-5133</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG 1, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>PHOENIX</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>13510 Blenheim Rd.</b>		10f. Zip Code <b>21131</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>MOVING + STORAGE</b>		
17. Father's Name (First, Middle, Last) <b>JOHN FORD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jenny BARRETT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bertha E. FORD /Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13510 Blenheim Rd. PHOENIX, MD. 21131</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY Mem Gdn</b>		20c. Location - City or Town, State <b>Timonium Md</b>		20d. Date <b>May 2, 1996</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL oS CHIMES</b> <b>2325 YORK Rd. Timonium Md. 21093</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of): b. <b>Diabetes Mellitus</b> Due to (or as a consequence of): c. <b>Arteriosclerosis</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D19166</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. J. Alan Baldanza 10629 YORK Rd. COCKEYSVILLE, MD. 21030</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental setup, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13039

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maude Louise GODWIN				2. Date of Death Month Day Year April 29, 1996		3. Time of Death 5:30 PM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-18-5107	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 22, 1905	9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 14 West Cold Spring Lane #812			10f. Zip Code 21210		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Frederick Clarence Berchdorf				18. Mother's Name (First, Middle, Maiden Surname) Minnie Browning			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Pearl Sewdass (friend)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Chesterton Road Baltimore, MD 21244				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		Date May 20,		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Staph aureus Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							2 weeks 2 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier K. Hatmaker				29c. License number R D 1914		29d. Date signed (Month, Day, Year) 4/29/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Katherine Hatmaker 9000 Franklin Square Dr. Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature J. Davidson						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13040

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP A. GLADDEN				2. Date of Death Month Day Year 4 30 96		3. Time of Death 9:30AM	
	4a. Facility Name (If not institution, give street and number) JOHN HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death CITY	
Funeral Director	5. Social Security Number 215-40-3337		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/22/1944	
	9. Birthplace (State or Foreign Country) BALTIMORE, MD.							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 940 N. EDEN STREET				10f. Zip Code 21205		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALEMAN		16b. Kind of Business/Industry LEVITS FURNITURE STORE			
	17. Father's Name (First, Middle, Last) EDWARD SHEILDS				18. Mother's Name (First, Middle, Maiden Surname) HELEN GLADDEN			
	19a. Informant's Name/Relationship (Type, Print) LUCINDA GLADDEN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 N. EDEN STREET, BALTIMORE, MARYLAND 21205			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Location - City or Town, State RANDALLSTOWN, MARYLAND		20d. Date 5/3/96	
	21. Signature of Funeral Service Licensee <i>Thyrl M. Estep</i>				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. CORONARY ARREST Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 20 MIN YRS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Richard F. Tyson</i>		29c. License number D10268	
	29d. Data signed (Month, Day, Year) 04-30-96							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard F. Tyson, M.D. 936 West North Ave. Balt. Md. 21217							
	31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13041

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DARLENE PATRICIA GREEN</b>						2. Date of Death Month Day Year <b>APRIL 30, 1996</b>		3. Time of Death <b>5:25PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>N.I.H. CLINICAL CENTER</b>						4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>218-56-2171</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 11, 1952</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent										
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number <b>3968 PENHURST AVE.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FAMILY THERAPIST</b>			16b. Kind of Business/Industry <b>PRIVATE</b>				
17. Father's Name (First, Middle, Last) <b>JOHN EVANS JR.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MURIEL PHILLIPS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MURIEL HOLMES / MOTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4112 GARRISON BLVD., BALTIMORE, MD. 21215</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		Data <b>5/6/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>					
21. Signature of Funeral Service Licensee <b>W.W. Chambers</b> MO0091				22. Name and Address of Facility <b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)										4 hours	
a. <b>Sepsis</b> Due to (or as a consequence of):											
b. <b>Bone Marrow Transplant with graft versus host disease</b> Due to (or as a consequence of):										75 days	
c. <b>Encephalopathy</b> Due to (or as a consequence of):										2 weeks	
d. <b>Pulmonary Aspergillosis</b> Due to (or as a consequence of):										1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robert L. Danner MD</b>									
29c. License number <b>D30712</b>		29d. Date signed (Month, Day, Year) <b>05/01/96</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert L. Danner M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>											
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13042

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEMUEL H. GRAHAM</b>			2. Date of Death Month <b>APRIL</b> Day <b>30</b> Year <b>1996</b>			3. Time of Death <b>3:45A.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>NA</b>			
Funeral Director	5. Social Security Number <b>213-10-4180</b>			6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth Month, Day, Year <b>May 6, 1918</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State <b>Maryland</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>1 Yes 2 No</b>	
	10e. Street and Number <b>633 N. Asquith St.</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>laborer</b>			16b. Kind of Business/Industry <b>shipyard</b>			
	17. Father's Name (First, Middle, Last) <b>Howard Thompson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Graham</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Faye Friend (daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8813 Falcon Ridge Drive, Baltimore, Md. 21133</b>						
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>David Ridge</b>			20c. Location - City or Town, State <b>May 6, 1996 Baltimore, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Carlton C. Douglas</b>			22. Name and Address of Facility <b>Douglas Funeral Service 1701 McCulloch St.</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>a. Gunshot wound of head</b>									
	Due to (or as a consequence of):									
	Due to (or as a consequence of):									
	Due to (or as a consequence of):									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARCINOMA OF PROSTATE</b>									
	23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>									
	24a. Was an autopsy performed? <b>Inspection</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>			26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>			28a. Date of Injury (Month, Day Year) <b>4 29 96</b>			28b. Time of Injury <b>1920P M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
				28d. Describe how injury occurred <b>SUBJECT SHOT SELF</b>			28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>633 ASQUITH ST. BALTIMORE MD</b>			
	29a. Certifier (Check only one) <b>25 Medical Examiner</b>			29b. Signature and title of certifier <b>Wayne D. Smith</b>						
				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>									
	State Registrar	31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>			32. Registrar's Signature <b>John Wilson-Randall</b>					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13043

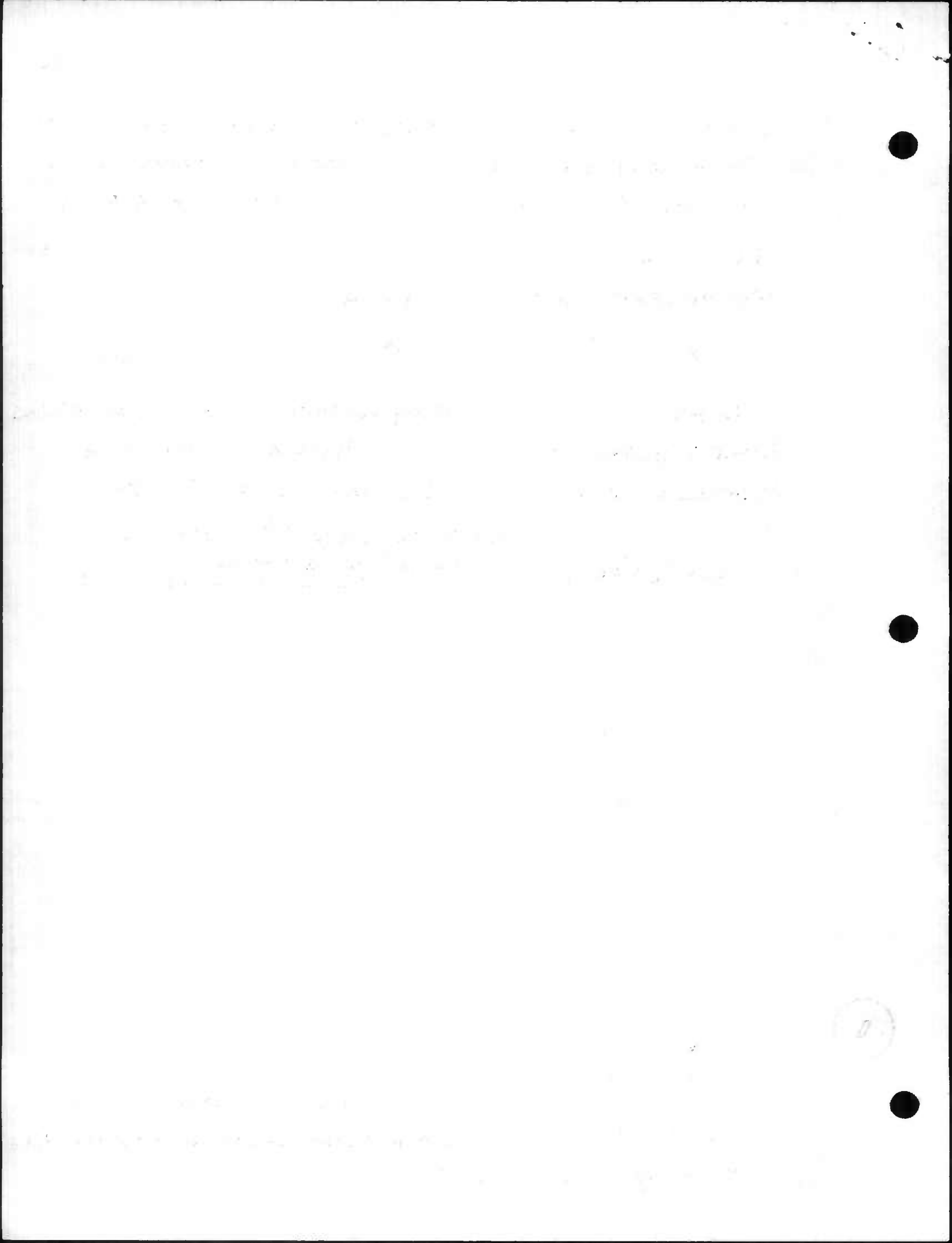
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT S GETTYS, JR.				2. Date of Death Month Day Year APRIL 28, 1996		3. Time of Death 2130PM	
	4a. Facility Name (If not institution, give street and number) ROUTE 30 AND MICHELLE ROAD				4b. City, Town, or Location of Death MANCHESTER		4c. County of Death CARROLL COUNTY	
Funeral Director	5. Social Security Number 170-30-2948		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 4, 1938	9. Birthplace (State or Foreign Country) YORK, PA.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State PA.	10b. County YORK	10c. City, Town or Location YORK			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2810 HIALEAH COURT				10f. Zip Code 17404		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs		College (1-4 or 5+) —		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FACTORY WORKER		16b. Kind of Business/Industry CASKET MANUFACTURING	
	17. Father's Name (First, Middle, Last) ROBERT S. GETTYS SR				18. Mother's Name (First, Middle, Maiden Surname) ALVERTA J. HOLLERBUSH			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MICHELLE L. GROVE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 STILLMEADOW LANE, PA. 17404			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALEM UNION CEMETERY		Date MAY 3, 1996		20c. Location - City or Town, State DOVER PA.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS FUNERAL CHAPEL 2325 YORK RD TIMONIUM 21093			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 4-28-96		28b. Time of Injury 21-26 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred Driver - Auto Auto collision				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Road way			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) RT 30				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 29, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13044

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gordon William Hare</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 1 1996</b>		3. TIME OF DEATH <b>11:30a M</b>	
4. SOCIAL SECURITY NUMBER <b>220-16-0710</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 9, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3137 Main Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Manchester</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Manchester</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3137 Main Street</b>	
10f. ZIP CODE <b>21102</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plumber</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jesse Carl Hare</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hilda Graf</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gene Hare</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4310 Miller Station Rd. Millers, Md. 21102</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Lutheran Cem. 5-3-96</b>		20c. LOCATION — City or Town, State <b>Manchester, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J. Hark Eckhardt</b>				22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>1 year</b> <b>10 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Arthur L. Rudo, MD ATTENDING PHYSICIAN</b>				29c. LICENSE NUMBER <b>D21155</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arthur L. Rudo, MD 904 Washington Rd Westminster, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

96 13045

Item 8, Film 735, 5/3/96, 1t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie W. Hohenberger</b>				2. Date of Death Month <b>April</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>9:30 P.M.</b>													
	4e. Facility Name (If not institution, give street and number) <b>6425 Woodland Forest Drive</b>				4b. City, Town, or Location of Death <b>Elkridge</b>		4c. County of Death <b>Howard</b>													
Funeral Director	5. Social Security Number <b>217-03-0442</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>7/5</b> <b>9-15-16</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>													
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Elkridge</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	10e. Street and Number <b>6425 Woodland Forest Drive</b>			10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>United States</b>														
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>														
	17. Father's Name (First, Middle, Last) <b>William Armin Auer</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Neukamm</b>																
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Steve Hohenberger Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>249 Lawyers Road N.W. Vienna, VA 22180</b>																
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Gardens</b>		Date <b>May 4,</b>		20c. Location - City or Town, State <b>Elkridge, Maryland</b>													
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="0"> <tr> <td rowspan="4">           immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>e. <b>RENAL FAILURE</b></td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>1990?</b></td> </tr> <tr> <td>b. <b>Hypertension</b></td> <td>Due to (or as a consequence of):</td> <td><b>1993</b></td> </tr> <tr> <td>c. <b>Primary Ureteral-Peritoneal Fibrosis</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>RENAL FAILURE</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1990?</b>	b. <b>Hypertension</b>	Due to (or as a consequence of):	<b>1993</b>	c. <b>Primary Ureteral-Peritoneal Fibrosis</b>	Due to (or as a consequence of):		d.	
immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>RENAL FAILURE</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1990?</b>																	
	b. <b>Hypertension</b>	Due to (or as a consequence of):	<b>1993</b>																	
	c. <b>Primary Ureteral-Peritoneal Fibrosis</b>	Due to (or as a consequence of):																		
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28d. Describe how injury occurred <b>as above</b>																
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 																		
		29c. License number <b>H-36245</b>		29d. Date signed (Month, Day, Year) <b>4-27-96</b>																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Belle Bauman, D.O. 5841 Washington Blvd. Elkridge, MD 21227</b>																				
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13046

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>RAYMOND JOSEPH HEATH</b>					2. Date of Death Month Day Year <b>APRIL 30, 1996</b>			3. Time of Death <b>3:21 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>					4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>			4c. County of Death <b>BALTIMORE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>218-10-8426</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 2, 1921</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2442 WOODCROFT ROAD</b>					10f. Zip Code <b>21234</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SET-UP</b>			16b. Kind of Business/Industry <b>COMMUNICATIONS</b>			
17. Father's Name (First, Middle, Last) <b>ARZIE HEATH</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN VOGT</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ROSE HEATH/SPOUSE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2442 WOODCROFT ROAD BALTIMORE, MD 21234</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>			20c. Location - City or Town, State <b>MAY 3, 1996, ROSEDALE, MARYLAND</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8200 HARFORD RD. Baltimore, Md. 21234</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS FROM</b>										<b>6 DAYS</b>
Due to (or as a consequence of): <b>RECURRENT ASPIRATION PNEUMONIA DUE TO</b>										<b>2-3 WEEKS</b>
Due to (or as a consequence of): <b>ABSENT SWALLOWING AND POOR PULMONARY TOILET</b>										<b>2-3 WEEKS</b>
Due to (or as a consequence of): <b>DUE TO CEREBROVASCULAR ACCIDENTS</b>										<b>2-4 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURE DISORDERS</b>  <b>CHRONIC RENAL FAILURE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury of Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>D27693</b>		29d. Date signed (Month, Day, Year) <b>5/1/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL A. HYLE, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>					32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ITEM: 1. PER F.H. 23 PART I, State of Maryland / Department of Health and Mental Hygiene  
27, PER MEO FILM G-735 5/3/96 t.t *Certificate of Death*

## Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) **WILLIAM GIBBS MACADOO HARDY, JR.**

2. Date of Death **APRIL 18, 1996**

3. Time of Death **9:30 PM**

4a. Facility Name (If not institution, give street and number) **2739 BRENDAN AVE.**

4b. City, Town, or Location of Death **BALTIMORE**

4c. County of Death **N/A**

5. Social Security Number **212-48-7785**

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday) **49** Yrs.

8. Date of Birth (Month, Day, Year) **2/11/47**

9. Birthplace (State or Foreign Country) **MARYLAND**

Usual Residence of Decedent

10a. State **MARYLAND**

10b. County **N/A**

10c. City, Town or Location **BALTIMORE CITY**

10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **2739 BRENDAN AVENUE**

10f. Zip Code **21213**

10g. Citizen of What Country? **USA**

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) **2 YEARS**

College (1-4 or 5+) **2 YEARS**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**SALES REPRESENTATIVE**

16b. Kind of Business/Industry **RETAIL**

17. Father's Name (First, Middle, Last) **WILLIAM HARDY, SR.**

18. Mother's Name (First, Middle, Maiden Surname) **ELSIE BLOCK**

19a. Informant's Name/Relationship (Type, Print) **WILLIAM G.M. HARDY, III SON**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1216 HALSTEAD RD. BALTIMORE, MD 21234**

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) **METRO CREMATORY, INC.**

Date **4/21/96**

20c. Location - City or Town, State **CATONSVILLE, MD**

21. Signature of Funeral Service Licensee **Christina L. Kopych**

22. Name and Address of Facility **JOHNSON FUNERAL HOME**

**8521 LOCH RAVEN BLVD. TOWSON, MD 21286**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disease or condition resulting in death)

a. **FATTY METAMORPHOSIS OF THE LIVER**

Due to (or as a consequence of):

b. **CHRONIC ALCOHOLISM**

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury **M**

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **[Signature]**

29c. License number **O.C.M.E.**

29d. Date signed (Month, Day, Year) **APRIL 17, 1996**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **111 Penn Street, Baltimore, Maryland 21201**

31. Date filed (Month, Day, Year) **MAY 03 1996**

32. Registrar's Signature **[Signature]**

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13048

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-15150-96

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD LESLIE HOLT			2. Date of Death Month Day Year APRIL 07, 1996		3. Time of Death 0950 AM		
	4a. Facility Name (If not institution, give street and number) 531 EAST WILLIAM STREET			4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 222-44-2898	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-24-1958	9. Birthplace (State or Foreign Country) DE.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 531 E. William St.			10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofers		16b. Kind of Business/Industry Carpenter			
	17. Father's Name (First, Middle, Last) Alfred E. Holt II			18. Mother's Name (First, Middle, Maiden Surname) Betty Barrall Hardesty				
	19a. Informant's Name/Relationship (Type, Print) Betty Hardesty			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 75 Delmar, De. 19940				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery		Date 4-10-96	20c. Location - City or Town, State Laurel, De.		
	21. Signature of Funeral Service Licensee <i>William M. Shortt</i>			22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. ACUTE ETHANOL AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) FOUND 4/7/96		28b. Time of injury 7:50 A M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28d. Describe how injury occurred UNKNOWN			
					28f. Location (Street and Number or Rural Route Number, City or Town, State) SALISBURY, MARYLAND 531 E. WILLIAM ST.			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Dennis J. Chute MD</i>			29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 8, 1996		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAY 03 1996			32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

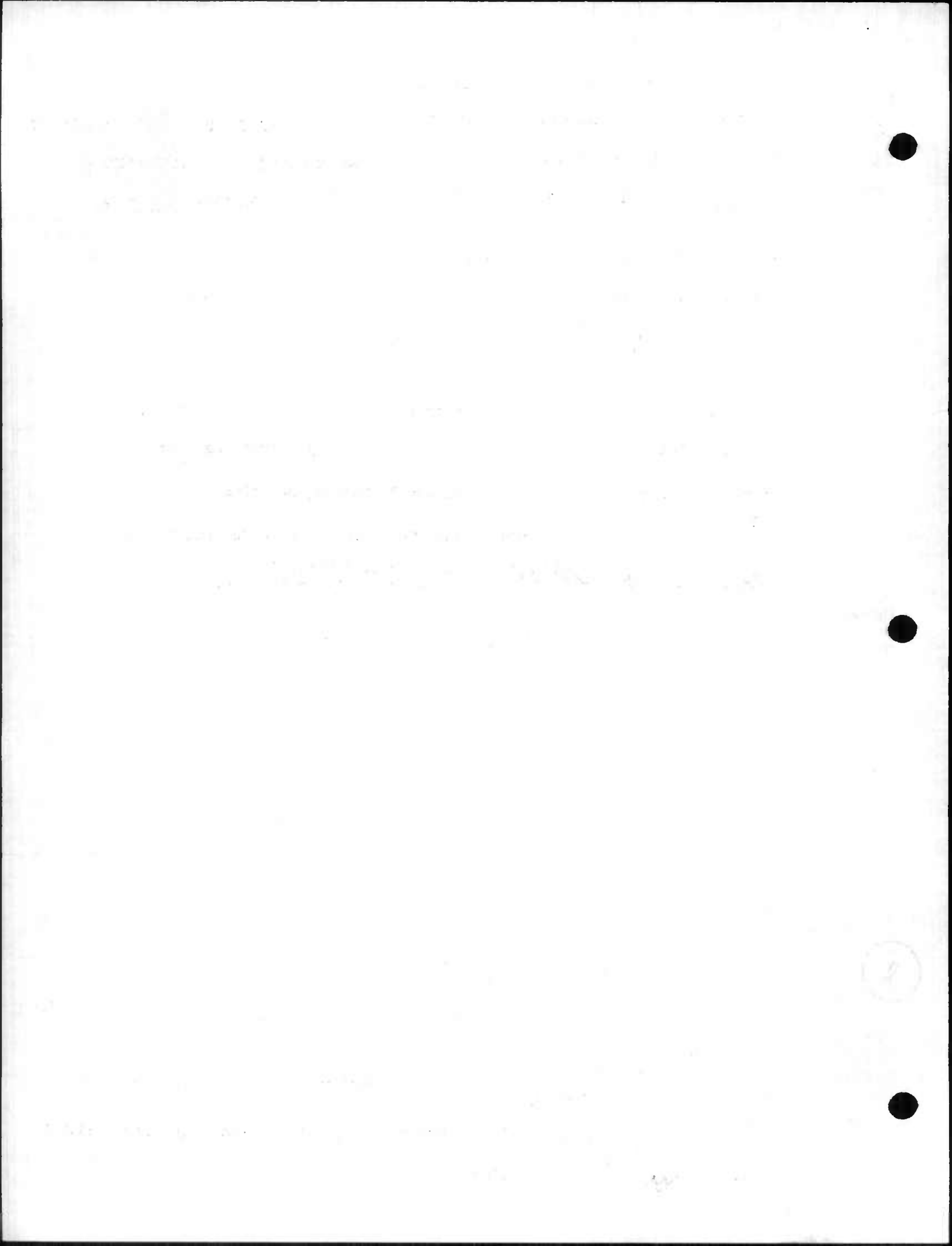
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

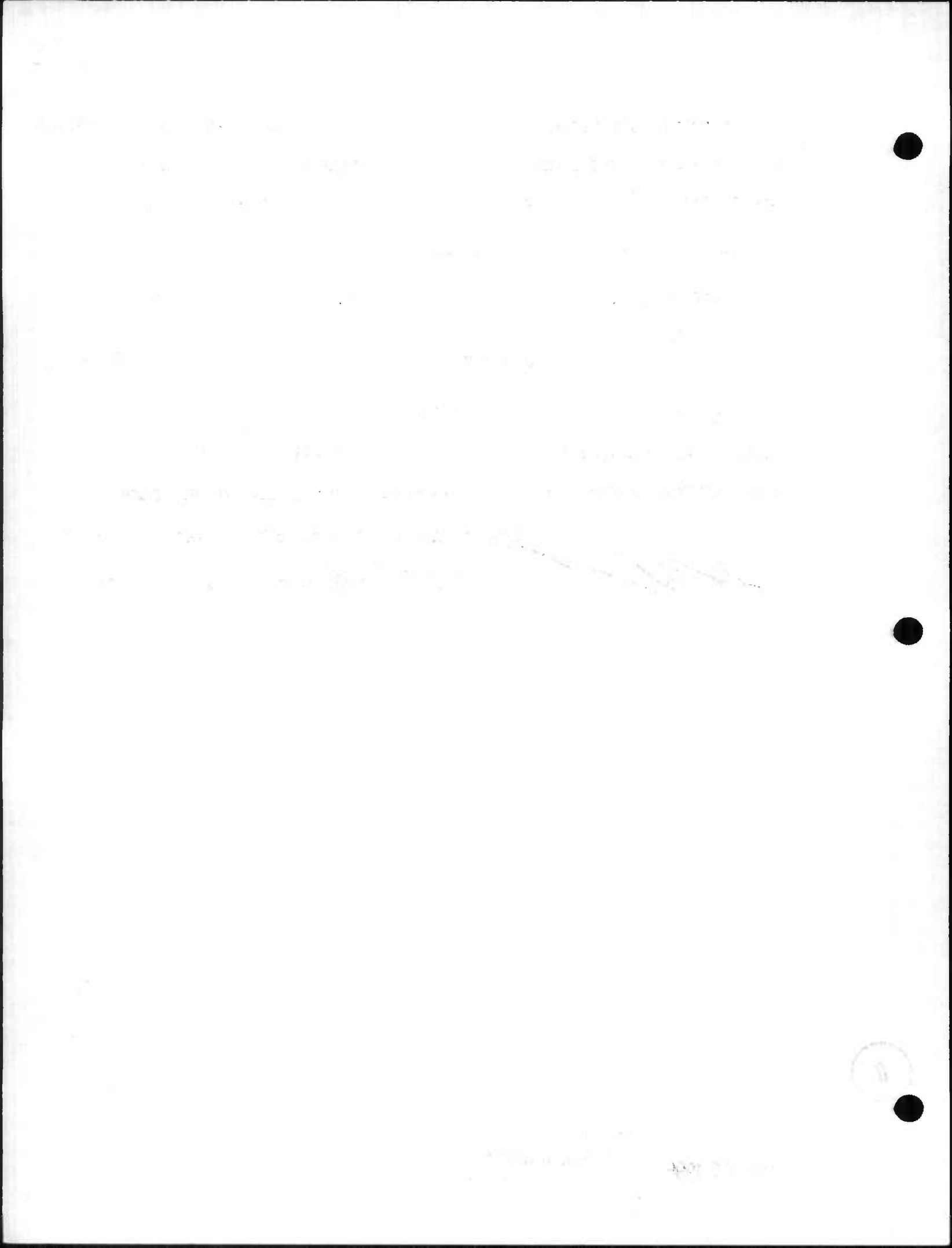
96 13049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACK ERNEST HARNSBERGER</b>						2. Date of Death Month Day Year <b>APRIL 30, 1996</b>		3. Time of Death <b>3:35 P.M.</b>	
	4e. Facility Name (If not Institution, give street and number) <b>DULANEY TOWSON NURSING HOME</b>						4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>226-07-3515</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8/3/19</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TOWSON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8119 KIRK WALL COURT</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1946</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>			18b. Kind of Business/Industry <b>SEARS</b>			
17. Father's Name (First, Middle, Last) <b>WILLIAM R. HARNSBERGER</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MATTIE L. LINSEY</b>				
19e. Informant's Name/Relationship (Type, Print) <b>ELIZABETH HARNSBERGER WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8119 KIRK WALL COURT TOWSON, MD 21286</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM. GAR.</b>		Date <b>5/4/96</b>		20c. Location - City or Town, State <b>COCKEYSVILLE, MD</b>		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Bladder Cancer</b> Due to (or as a consequence of): b. <b>Dehydration</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Sireesh K. Tripurani</b>				29c. License number <b>D 30661</b>		29d. Date signed (Month, Day, Year) <b>May 1st 1996</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SIREESH K. TRIPURANI 5670 The Adameda Baltimore Md - 21239</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1041





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State of Maryland / Department of Health and Mental Hygiene

96 13050

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THOMAS DAVID HILTE, SR.</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>96</b>		3. Time of Death <b>6:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>	
Funeral Director	5. Social Security Number <b>214-26-7102</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1927</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>9106 Orbitan Road</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4or 5+) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Coffee Company</b>	
	17. Father's Name (First, Middle, Last) <b>Thomas David Hilte, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Molly Drucilla Horner</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Alva Marie Hilte / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9106 Orbitan Road, Baltimore, Maryland 21234</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>5/2/96</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>LUNG CANCER</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Kendall Faulkner, 2300 Dulaney Valley Road, Towson, Maryland 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



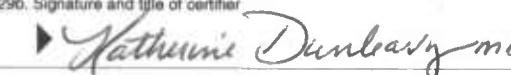
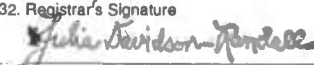
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13051

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIOLA G. Clara Viola JOHNSON</b>				2. Date of Death Month Day Year <b>APRIL 30, 1996</b>		3. Time of Death <b>10:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>218-22-9868</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUL 18, 1924</b>	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1003 N. GAY STREET</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3 rd</b>		College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>IN OWN HOME</b>	
	17. Father's Name (First, Middle, Last) <b>JESSE WILLS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH LAWRENCE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MAE ALSTON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1023 BRANCHWATER COURT., BALTIMORE, MD 21205</b>			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL</b>		Date <b>5-6</b>		20c. Location - City or Town, State <b>LAUREL, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WM. C. MARCH FH. 1101 E. NORTH AVENUE</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CHRONIC PULMONARY EMBOLISMS</b> 5 YEARS Due to (or as a consequence of): b. <b>PULMONARY HYPERTENSION</b> 5 YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GRAVES DISEASE, HYPERTENSION,</b>							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>N2515</b>			
	29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) <b>APRIL 30, 1996</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 N. WOLFE STREET, BALTIMORE, MARYLAND 21218</b>							
	31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13052

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <u>Guy Johnson</u>						2. Date of Death Month <u>April</u> Day <u>27</u> Year <u>1996</u>		3. Time of Death <u>5:30 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>VILLA ST. MICHAEL</u>						4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
<b>Funeral Director</b>	5. Social Security Number <u>100-42-6660</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>71</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Sept. 14, 24</u>		9. Birthplace (State or Foreign Country) <u>Trinidad</u>	
	Usual Residence of Decedent									
<b>To Be Completed by Funeral Director</b>	10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <u>1400 E. Madison Street</u>				10f. Zip Code <u>21205</u>		10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cleaner</u>			16b. Kind of Business/Industry <u>Cleaning Service</u>		
	17. Father's Name (First, Middle, Last) <u>George Johnson</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Vanessa (Unknown)</u>			
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <u>Patrick Simon / brother</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3601 Dorchester St. Baltimore, MD. 21215</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Western Star Cemetery</u>		Date		20c. Location - City or Town, State <u>Baltimore, Maryland</u>			
	21. Signature of Funeral Service Licensee <u>Leroy O. Dyett</u>				22. Name and Address of Facility <u>LEROY O. DYETT &amp; SON FUNERAL HOME</u> <u>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>epiglottic cancer</u> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>&gt;1 year</u></p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year)		28b. Time of injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <u>Harold Bob</u>				29c. License number <u>D15872</u>		29d. Date signed (Month, Day, Year) <u>April 29, 1996</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Harold Bob 7220 Park Heights Ave Baltimore MD 21208</u>										
31. Date filed (Month, Day, Year) <u>MAY 03 1996</u>				32. Registrar's Signature <u>J. H. Madison-Randall</u>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13053

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHRISTENA M. JONES</b>				2. Date of Death Month Day Year <b>April 30th 1996</b>		3. Time of Death <b>5:00 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>3909 Noyes Circle Apt 2</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore Co.</b>		
Funeral Director	5. Social Security Number <b>217-24-2406</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 25 1929</b>	9. Birthplace (State or Foreign Country) <b>LOUISIANA</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE CO.</b>		10c. City, Town or Location <b>RANDALLSTOWN</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3909 Noyes Circle Apt 2</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Aide</b>		16b. Kind of Business/Industry <b>Mercy Hospital</b>				
	17. Father's Name (First, Middle, Last) <b>Soloman Smooth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Lee Hayes</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Annette Clark/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6403 Liberty Road, Baltimore, Maryland 21207</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>5/3/96 Woodlawn, Md.</b>				
	21. Signature of Funeral Service Licensee <b>Hani G. Close</b>		22. Name and Address of Facility <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cancer of Lung with metastases</b> Due to (or as a consequence of):  <b>b. metastases</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>								
	23b. Did tobacco use contribute to the cause of death? <b>1 <input checked="" type="checkbox"/> Yes</b> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>T. Kawata</b>				29c. License number <b>D25112</b>		29d. Date signed (Month, Day, Year) <b>April 30th 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TAHOORA KAWATA 5310 Old Court Rd Randallstown MD 21133</b>									
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>J. K. [Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

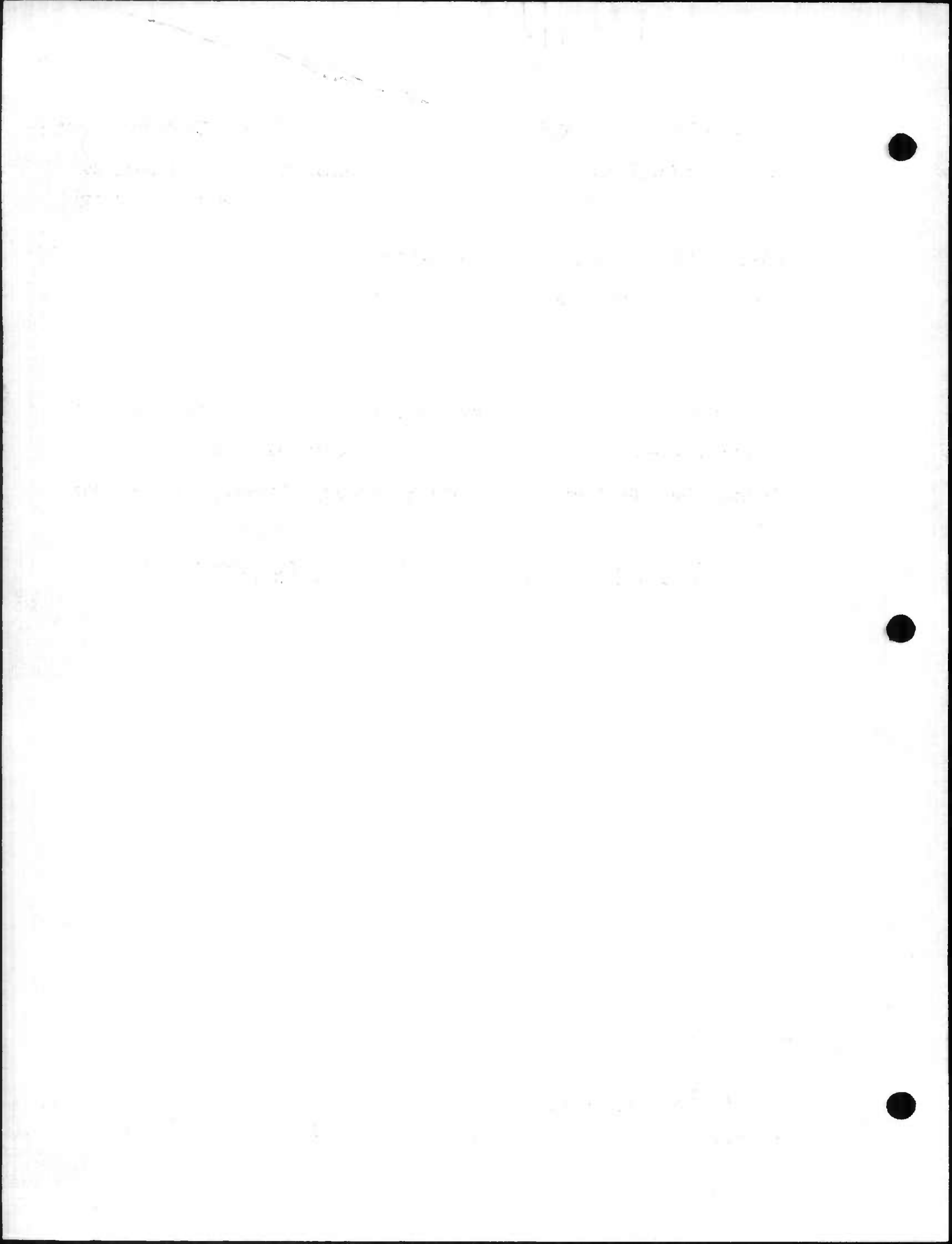
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13054

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>DOROTHY E. JOHNSON</b>		2. Date of Death Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>10:45A</b>	
4a. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>218-10-0031</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 16 1914</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. State <b>MARYLAND</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4017 LIBERTY HEIGHTS AVE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Edgewood Arsenal</b>			
17. Father's Name (First, Middle, Last) <b>JAMES H. TAYLOR</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>BLANCHE WEATHERS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>FAWN R. HUBBARD/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>826 N. Carey Street, Baltimore, MD. 21217 1st. Floor</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. Location - City or Town, State <b>5-3-96 BALTIMORE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WILLIAM C. BROWN COMMUNITY F/R 1206 W. NORTH AVENUE</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPTIC SHOCK.</b> Due to (or as a consequence of): <b>END STAGE RENAL DISEASE</b> Due to (or as a consequence of): <b>DIABETES MELLITUS</b> Due to (or as a consequence of): <b>DEMENCIA</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>1 day</b> <b>UNKNOWN</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>DIABETES MELLITUS</b> <b>DEMENCIA</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>MD.</b>		29c. License number <b>D 23300</b>		29d. Date signed (Month, Day, Year) <b>APRIL 28 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUDHIR D. PATEL 2600 KILBURN RD. BALTO MD. 21215</b>					
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 			



96-2271-043

CIP

ITEMS: 23 PART I, 27, PER MED  
FILM G-735 5/10/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13055

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WARREN

WESLEY

KETTOMAN

2. Date of Death

Month Day Year  
APRIL 26, 1996

3. Time of Death

8:00AM

4a. Facility Name (If not institution, give street and number)

#66 WAYSIDE AVENUE

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

169-38-5765

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

08-31-46

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

66 Wayside Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Automotive Manf.

17. Father's Name (First, Middle, Last)

George D. Kettoman

18. Mother's Name (First, Middle, Maiden Surname)

Margaret L. Wetzel

19a. Informant's Name/Relationship (Type, Print)

Darlene Bowman/ Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

66 Wayside Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fairfield Union Cemetery

Date

4-30-96

20c. Location - City or Town, State

Fairfield, Pa. 17320

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Clarence E. Wilson 25 East Main Street  
Fairfield, Pa. 17320

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

performed?

1 ☒ Yes 2 ☐ Nocompletion of cause  
of death?1 ☒ Yes 2 ☐ No

25. Was case referred to medical

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



G-735 5/22/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD WAYNE KULLER				2. Date of Death Month Day Year APRIL 27, 1996		3. Time of Death 17:00 P		
	4a. Facility Name (If not institution, give street and number) 1106 FOXWOOD LN.				4b. City, Town, or Location of Death ESSEX		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-64-1991	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 2 1959		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location ESSEX			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1106 FOXWOOD LN			10f. Zip Code 21220		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RESEARCH ASSISTANT		16b. Kind of Business/Industry SAFT BATTERIES				
	17. Father's Name (First, Middle, Last) JAMES G. KULLER				18. Mother's Name (First, Middle, Maiden Surname) Jeanne Regus				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JAMES G. KULLER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 RODES VALLEY DR. NELLYSFORD VA 22958					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount		20c. Location - City or Town, State Balto. Md		20d. Date MAY 2 1996	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. BALTO. MD. 21234					
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. KETOACIDOSIS WITH FATTY LIVER Due to (or as a consequence of):  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) APRIL 28, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MAYORSON P. KOSOW 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13057

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CLAUDE LAMBERT JR

2. Date of Death  
Month Day Year

APRIL 23 96

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

NORTHWEST MEDICAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTO.

5. Social Security Number

212 80 8965

6. Sex

1# M 2# F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/7/58

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1# Yes 2# No

10e. Street and Number

1006 WILDWOOD PKY.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1# Navar Married 2# Married  
3# Widowed 4# Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1# Yes 2# No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1# Yes 2# No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR ASSISTANT

16b. Kind of Business/Industry

MEYERHOFF SYMPHONY HALL

17. Father's Name (First, Middle, Last)

CLAUDE W. LAMBERT SR.

18. Mother's Name (First, Middle, Maiden Surname)

NAOMI LAMBERT

19a. Informant's Name/Relationship (Type, Print)

CLAUDE W. LAMBERT SR. FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3513 ROCKDALE CT. ROCKDALE. MD. 21244

20a. Method of Disposition

1# Burial 2# Cremation 3# Removal from State  
4# Donation 5# Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING'S PARK 4/29/96

Date

20c. Location - City or Town, State

RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA  
Due to (or as a consequence of):

1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPTIC SHOCK  
Due to (or as a consequence of):

1 DAY

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE HUMAN IMMUNODEFICIENCY

VIRUS

23b. Did tobacco use contribute to the cause of death?

1# Yes 2# No 3# Probably 4# Unknown

24a. Was an autopsy performed?

1# Yes 2# No

24b. Were autopsy findings available prior to completion of cause of death?

1# Yes 2# No

25. Was case referred to medical examiner?

1# Yes 2# No

Hospital:

1# Inpatient 2# ER/Outpatient 3# DOA

28. Place of Death (Check only one)

Other: 4# Nursing Home 5# Residence 6# Other (Specify)

27. Manner of Death

1# Natural 2# Accident 3# Suicide 4# Homicide  
5# Pending investigation 6# Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1# Yes 2# No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1# Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2# Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P Mehta M.D.

29c. License number

DA1410

29d. Date signed (Month, Day, Year)

APRIL 23, 96.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13058

Item: 31 per F.H. G-735 5/3/96 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward

Lewis

2. Date of Death

Month Day Year

MAY 2 1996

3. Time of Death

1:35 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-38-3144

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

54 Yrs.

8. Date of Birth

Month Day Year

May 14, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 X Yes 2 No

10e. Street and Number

5109 Chalgrove Ave.

10f. Zip Code

21215

10g. Citizen of What Country

USA

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 10 College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Home Improvement

17. Father's Name (First, Middle, Last)

Raymond T. Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Alta Virginia Cross

19a. Informant's Name/Relationship (Type, Print)

Mrs. Kathryn L. Lewis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5109 Chalgrove Ave. Balto, Md. 21215

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Luke's Cem.

20c. Location - City or Town, State

Date

5/7/96

Reisterstown, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Terminal pharynx cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. lung Metastasis

Due to (or as a consequence of):

c. Upper GI Bleeding

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural  
2 Accident  
3 Suicide  
4 Homicide5 Pending Investigation  
6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.R. Zindlerhaid, M.D.

29c. License number

89256

29d. Date signed (Month, Day, Year)

5-2-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.R. Zindlerhaid, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

5-2-96

32. Registrar's Signature

MAY 03 1996

Julia Davidson-Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



## Reg. No.


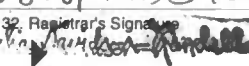
DHHM 16 Rev 6/95



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13060

Reg. No.

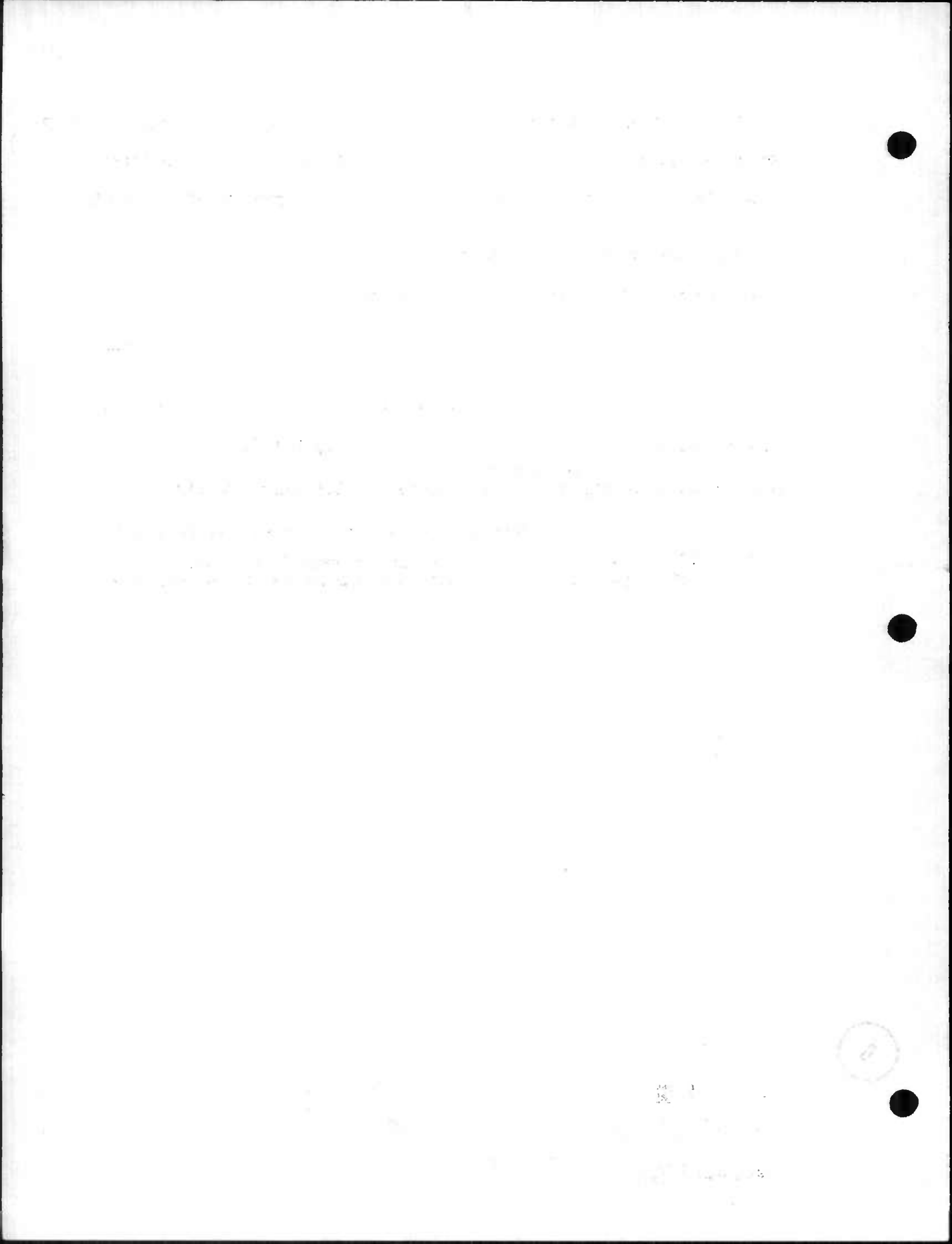
<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Esther Anne Laisure</b>					2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>1:45 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>606 Hyde Park Road</b>					4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>		
<b>Funeral Director</b>	5. Social Security Number <b>215-18-6938</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 19, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1000 Franklin Avenue Apt. 705</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aid</b>			16b. Kind of Business/Industry <b>Health Care</b>			
17. Father's Name (First, Middle, Last) <b>John L. Gardner</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy V. Mair</b>					
19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) <b>Margaret Elizabeth Sippel</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>925 Maldon Rd. Baltimore, Md. 21239</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>			Data <b>5/3/1996</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>					
23a. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Recurrent CVA</b></p> <p>b. <b>Sick Sinus Syndrome</b></p> <p>c. <b></b></p> <p>d. <b></b></p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>2 Hrs</b></p> <p><b>2 Yrs</b></p> </div> </div> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>D30641</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMESH SABARWAL MD 3400 Erdman Ave Baltimore MD 21213</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 to the Hospital or Attending Physician: The law requires that the death certificate be executed within 4 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
 To Be Completed by Physician/Medical Examiner

**State  
Registrar**



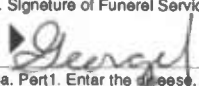
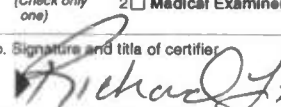
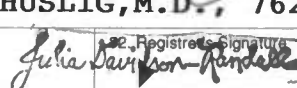
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13061

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTELLE C AATHERINE MAGLIANO</b>				2. Date of Death Month Day Year <b>MAY 01, 1996</b>		3. Time of Death <b>7:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>216-58-0462</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 28, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>204 E. Joppa Road</b>		10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>John Brady</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary O'Hara</b>		19a. Informant's Name/Relationship (Type, Print) <b>Dolores R. Munafo (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Lochview Terrace Timonium, Maryland 21093</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem.</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>AROTIC ENCEPHALOPATHY</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 36814</b>		
29d. Date signed (Month, Day, Year) <b>MAY 01, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RICHARD L. HUSLIG, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>		31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is devoted to a general survey of the situation in the country. It is followed by a detailed analysis of the economic situation, which is the main subject of the report. The third part of the report is devoted to a detailed analysis of the social situation, which is the main subject of the report. The fourth part of the report is devoted to a detailed analysis of the political situation, which is the main subject of the report.

2. The second part of the report is devoted to a detailed analysis of the economic situation. It is followed by a detailed analysis of the social situation, which is the main subject of the report. The third part of the report is devoted to a detailed analysis of the political situation, which is the main subject of the report.

3. The third part of the report is devoted to a detailed analysis of the social situation. It is followed by a detailed analysis of the political situation, which is the main subject of the report. The fourth part of the report is devoted to a detailed analysis of the economic situation, which is the main subject of the report.

4. The fourth part of the report is devoted to a detailed analysis of the political situation. It is followed by a detailed analysis of the economic situation, which is the main subject of the report. The fifth part of the report is devoted to a detailed analysis of the social situation, which is the main subject of the report.

5. The fifth part of the report is devoted to a detailed analysis of the economic situation. It is followed by a detailed analysis of the social situation, which is the main subject of the report. The sixth part of the report is devoted to a detailed analysis of the political situation, which is the main subject of the report.

6. The sixth part of the report is devoted to a detailed analysis of the social situation. It is followed by a detailed analysis of the political situation, which is the main subject of the report. The seventh part of the report is devoted to a detailed analysis of the economic situation, which is the main subject of the report.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13063

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL MACK

2. Date of Death

April 29 1996 11:00 pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

212-44-5570

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 12 1948

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

1330 Division Street

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Robert Mack

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Gaston Mack

19a. Informant's Name/Relationship (Type, Print)

Patricia Mack/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6121 St. Regis Road, BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

KING MEMORIAL PARK

Date

5-3-96

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

H. P. Clore

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC ADENOCARCINOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 Investigation  
3 Suicide 6 Could not be  
4 Homicide 6 determined

28a. Date of injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?

1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Martin Linker MD

29c. License number

D39858

29d. Date signed (Month, Day, Year)

APRIL 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN LINKER M.D. Maryland General Hospital

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

Julia [Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13064

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cora ANN Miller				2. Date of Death Month Day Year April 27 1996		3. Time of Death 10:59 AM	
	4a. Facility Name (If not Institution, give street and number) BEL AIR NURSING CENTER				4b. City, Town, or Location of Death BEL AIR		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 162-14-0619	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 24, 1919		9. Birthplace (State or Foreign Country) PENNSYLVANIA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County HARFORD	10c. City, Town or Location WHITE HALL			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2417 HARKINS ROAD			10f. Zip Code 21161		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 YRS -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST OPERATOR		18b. Kind of Business/Industry REAL ESTATE CO.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) BENJAMIN LYMAN JOHNS				18. Mother's Name (First, Middle, Maiden Surname) MARGARET LUCINDA EVANS			
	19a. Informant's Name/Relationship (Type, Print) ROY L. MILLER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 HARKINS RD. WHITE HALL 21161			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CREMATORY		Date 4-30		20c. Location - City or Town, State BALTIMORE	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR 3 NEWPORT DRIVE 21050			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>cardiac cancer</u> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's disease (Dementia)</u> <u>Smoking No</u>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier [Signature]				29c. License number 027975		29d. Date signed (Month, Day, Year) 4/27/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) POUND McClure MD 615 W. Macphail Rd Bel Air, MD 21014							
	31. Date filed (Month, Day, Year) MAY 3 1996				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



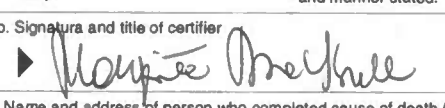
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13065  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) ABRIAN ANTONIO MOORE				2. Date of Death Month Day Year APRIL 29 1996		3. Time of Death 11:00A.M			
4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a			
5. Social Security Number 219-33-6624		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 4 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 14, 1991			
9. Birthplace (State or Foreign Country) MARYLAND									
Usual Residence of Decedent									
10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 821 W. LEXINGTON ST.,				10f. Zip Code 21223		10g. Citizen of What Country? UNITED STATES			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHILD		16b. Kind of Business/Industry n/a			
17. Father's Name (First, Middle, Last) TABIAN MOORE SR.				18. Mother's Name (First, Middle, Maiden Surname) TANYA WALLER					
19a. Informant's Name/Relationship (Type, Print) TANYA WALLER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 W. LEXINGTON ST., BALTIMORE, MD					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition Balto. Cemetery <del>KING MEMORIAL PARK</del>		Date 5-6		20c. Location - City or Town, State Balto. MD <del>RANDALLSTOWN, MD</del>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AVE.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUNDS TO HEAD AND CHEST Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		26a. Date of Injury (Month, Day, Year) 4-21-96		26b. Time of Injury 1951 P M		26c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		26d. Describe how injury occurred GUNSHOT WOUNDS		26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET					
		26f. Location (Street and Number or Rural Route Number, City or Town, State) 8376 LEXINGTON BALTIMORE MD							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  M. J. Jones							
		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 30, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARYANN A. KOSAR MM. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

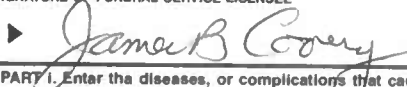
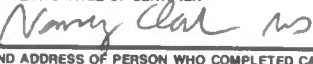
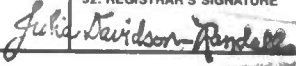




96 13066

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Doris A. Van Meter</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>2</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0250 A M</b>	
4. SOCIAL SECURITY NUMBER <b>511-26-9597</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 12, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>England</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Randallstown</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3818 Brownhill Road</b>	
10f. ZIP CODE <b>21133</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 Years</b> College (1-4 or 5+) <b>4 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Air Intelligence</b>		16b. KIND OF BUSINESS/INDUSTRY <b>London Air Force</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Albert Stanley Gravett</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Jane Sharp</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Francine Van Meter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Englefield Square Owings Mills, MD 21117</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Memorial Park 5/3/96</b>		20c. LOCATION — City or Town, State <b>Pikesville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>AT2438946E28</b>		29d. DATE SIGNED (Month, Day, Year) <b>05/01/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Union Memorial Hospital Baltimore, MD NANCY CLARK</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


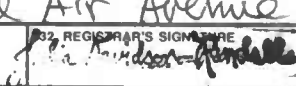
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13067

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DON MARIC MERSHON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26, 1996</b>				3. TIME OF DEATH <b>3:55 P.M.</b>			
4. SOCIAL SECURITY NUMBER <b>216-38-4905</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 30, 1942</b>		8. BIRTHPLACE (State or Foreign Country) <b>MICHIGAN</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FALLSTON GENERAL HOSP</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>FALLSTON</b>				9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>JARRETTSVILLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4114 MANOR VIEW CT.</b>						10f. ZIP CODE <b>21084</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE.</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b> College (1-4 or 5+) <b>-</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALES</b>				15b. KIND OF BUSINESS/INDUSTRY <b>SELF-EMPLOYED</b>			
17. FATHER'S NAME (First, Middle, Last) <b>VERL MERSHON</b>						16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NETTIE EMERTON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>KATHERINA J. MERSHON</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4114 MANOR VIEW CT. HARFORD 21084</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREENMOUNT CREMATORY 4/29</b>				20c. LOCATION — City or Town, State <b>BALTIMORE</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL BELAIR 3 NEWPORT DRIVE 21050</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute pancreatitis</b>											
DUE TO (OR AS A CONSEQUENCE OF): <b>alcohol abuse</b>											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cinthosis, coagulopathy liver failure</b>											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Harry Sam Kim</b>						29c. LICENSE NUMBER <b>D37364</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 27, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>219 West Bel Air Avenue, Aberdeen, Maryland 21001</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13068

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris Jane Mayer</b>						2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>5:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>545 Woodlyn Terrace</b>						4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>196-14-8200</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 9, 1923</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>545 Woodlyn Terrace</b>						10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>			16b. Kind of Business/Industry <b>Eastpoint Mall</b>			
17. Father's Name (First, Middle, Last) <b>HARVEY Mather</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Olwine</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Bellamy</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>545 Woodlyn Terrace Baltimore Md. 21221</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery</b>			Date <b>5/4/96</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>ALZHEIMER'S DISEASE</b> Due to (or as a consequence of):										YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, PARKINSON'S DISEASE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  <b>D.O.</b>			29c. License number <b>H35593</b>			29d. Date signed (Month, Day, Year) <b>MAY 2, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. JOHN W. LOH 1124 MACE AVE., BALTIMORE, MD. 21221</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To file Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To file Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13069

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHRYN M. MITCHELL</b>				2. Date of Death Month Day Year <b>APRIL 29, 1996</b>				3. Time of Death <b>4:49 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-20-9508</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 30, 1914</b>		9. Birthplace (State or Foreign Country) <b>Balto. City, Md.</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>White Marsh</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>11616 Jerome Avenue</b>				10f. Zip Code <b>21162</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) <b>8th.</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>				16b. Kind of Business/Industry <b>A &amp; P Market</b>				17. Father's Name (First, Middle, Last) <b>Edward O'Laughlin</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Witte</b>				19a. Informant's Name/Relationship (Type, Print) <b>Shirley M. Kemmerzell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11616 Jerome Avenue White Marsh, Md. 21162</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery May 2, 1996</b>				20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>E. F. Lassahn</b>				22. Name and Address of Facility <b>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of): <b>ISCHEMIC PERIPHERAL VASCULAR DISEASE</b> Due to (or as a consequence of): <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>RESPIRATORY INSUFFICIENCY</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <b>Richard L. Linthicum</b>				29c. License number <b>D31826</b>				29d. Date signed (Month, Day, Year) <b>4-29-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RICHARD L. LINTHICUM, M.D., SAINT JOSEPH MEDICAL CENTER</b>				31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <b>Julia Hudson-Pendle</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13070

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DENNIS M. McCord</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>6 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>6003 Falls Road Apt. 3</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>220-42-8901</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 4, 1945</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>6003 Falls Road Apt. 3</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+) <b>Cashier</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>WAWA Foods Inc.</b>	
	17. Father's Name (First, Middle, Last) <b>Elmer McCord</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Jeanette Butler</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Sharon McArdle</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6003 Falls Road Apt. 3 Baltimore, Maryland 21209</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		Date <b>5/3/96</b>		20c. Location - City or Town, State <b>Pikesville, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Lucy Dennis Carpenter</i>				22. Name and Address of Facility <b>Burgee-Henss Funeral Home</b> <b>3631 Falls Road Baltimore, Maryland 21211</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Arrest</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of): d. <b>Squamous Cell Carcinoma - Neck</b> 2 yrs.  Approximate Interval Between Onset and Death <b>minutes</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Robert C. Irwin MD</i>				
				29c. License number <b>D08980</b>		29d. Date signed (Month, Day, Year) <b>5-3-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert C. Irwin MD 828 N. Cedar St. Baltimore 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <i>John Taylor</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13071

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol B. Miller				2. Date of Death Month Day Year April 30, 1996				3. Time of Death 11:55am	
	4e. Facility Name (If not institution, give street and number) 830 West 40th Street				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-34-6526		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 31 yrs		8. Date of Birth (Month, Day, Year) Feb 22, 1915		9. Birthplace (State or Foreign Country) Michigan	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 830 West 40th Street				10f. Zip Code 21211		10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Unk				18. Mother's Name (First, Middle, Maiden Surname) Clara					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jerome Miller (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 W. Myrtle Street, Littlestown, Pa. 17340					
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 5/2/96		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee A. Alan Seitz, Jr.				22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md. 21211					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Squamous Cell Lung Cancer 15 months Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Osteoarthritis Hyperlipidemia									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier William J. McConnell M.D.		29c. License number D42129		29d. Date signed (Month, Day, Year) 5-2-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William McConnell 500 W. University Baltimore MD									
	31. Date filed (Month, Day, Year) MAY 03 1996									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

13072

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH McComb NICHOLS</b>				2. Date of Death Month Day Year <b>MAY 1 1996</b>		3. Time of Death <b>4:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-07-7725</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 6, 1919</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Towson</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		
To Be Completed by Funeral Director		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Certified Public Accountant</b>	
		16. Kind of Business/Industry <b>Accounting</b>		17. Father's Name (First, Middle, Last) <b>Joseph Edge Nichols</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Emig</b>		19. Intendant's Name/Relationship (Type, Print) <b>Helen McCall Nichols/wife</b>	
To Be Completed by Physician/Medical Examiner		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>512 Wilton Rd.</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Baltimore</b>	
		21. Signature of Funeral Service Licensee <b>John O. Mitchell IV</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> Due to (or as a consequence of): <b>URINARY TRACT INFECTION</b> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEMATURIA</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
		29b. Signature and title of certifier <b>Dr. Murray MD</b>		29c. License number <b>D47993</b>		29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GABRIEL NAZARENO 5601 LOCH RAVEN BLVD BALTO MD 21239</b>							
		31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>John A. [Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

5



96 13073

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR ZAHNISR NIXON, Jr.</b>				2. DATE OF DEATH MONTH <b>04</b> / DAY <b>30</b> / YEAR <b>96</b>		3. TIME OF DEATH <b>9 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-30-8196</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06/26/33</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>412 W. Market Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SNOW Hill</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>412 W. Market Street</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sheet Metal Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Local 100</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Nixon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Mae Wheeler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>June L. Foy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4135 Little Road Whiteford Md. 21160</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 5/4/96</b>		20c. LOCATION — City or Town, State <b>Rossville Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Turry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>FEW MONTHS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dorothy C. Holzworth M.D.</b>				29c. LICENSE NUMBER <b>D06341</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-30-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13074

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED E. NEUMAN

2. Date of Death

Month Day Year  
APRIL 23, 1996

3. Time of Death

8:10 AM

4a. Facility Name (If not institution, give street and number)

CROMWELL CENTER GENESIS ELDERCARE

4b. City, Town, or Location of Death

PARKVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

217-09-0562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 14, 1919

9. Birthplace (State or Foreign Country)

Balto.

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

600 LIGHT ST. APT 912

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTOMER SERVICE

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

SAMUEL NEUMAN

18. Mother's Name (First, Middle, Maiden Surname)

ADA JACOBS

19a. Informant's Name/Relationship (Type, Print)

JOAN LAMBDIN /niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2414 LAKEWOOD Rd Balto. MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN

Date

April 24 1996

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES  
8800 HARFORD Rd. BALTO. MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic coronary artery disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Marion C. Kowalewski MD*

29c. License number

D21022

29d. Date signed (Month, Day, Year)

4-23-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARION C. KOWALEWSKI

8604 HARFORD Rd Balto. Md. 21234

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

*Julia Hudson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. In the second part, we shall consider the question of the influence of the external magnetic field on the energy levels of the atom.

3. The third part of the paper is devoted to a detailed analysis of the results of the calculations of the energy levels of the atom.

4. In the fourth part, we shall consider the question of the influence of the external electric field on the energy levels of the atom.

5. The fifth part of the paper is devoted to a detailed analysis of the results of the calculations of the energy levels of the atom.

6. In the sixth part, we shall consider the question of the influence of the external magnetic field on the energy levels of the atom.

7. The seventh part of the paper is devoted to a detailed analysis of the results of the calculations of the energy levels of the atom.

8. In the eighth part, we shall consider the question of the influence of the external electric field on the energy levels of the atom.

9. The ninth part of the paper is devoted to a detailed analysis of the results of the calculations of the energy levels of the atom.

10. In the tenth part, we shall consider the question of the influence of the external magnetic field on the energy levels of the atom.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13075

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN L. OLIPHANT, SR.

2. Date of Death

Month Day Year  
APRIL 28 1996

3. Time of Death

1:40 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

250-12-0569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

8. Date of Birth

Month Day Year  
OCT. 2, 1920

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 GAROBE COURT

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

STEEL MANUFACTURING

17. Father's Name (First, Middle, Last)

GEORGE WILLIAM OLIPHANT

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE MAE SELLGER

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY WILLIAMS / FIANCÉE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 GAROBE COURT, BALTIMORE, MARYLAND 21207

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

MAY 2, 1996

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LOUDON PARK FUNERAL HOME, INC.  
3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

7 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 43462

29d. Date signed (Month, Day, Year)

APRIL 28 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN M.D.

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

1940

2001-01-15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13076

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary A. ORTEL			2. Date of Death Month Day Year May 2, 1996		3. Time of Death 9:00 am.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital			4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore county	
Funeral Director	5. Social Security Number 218-12-7068	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 14, 1923	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2306 Martin Road			10f. Zip Code 21221		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Charles E. Able				18. Mother's Name (First, Middle, Maiden Surname) Nellie Ella Phillips			
19a. Informant's Name/Relationship (Type, Print) Grant Ortel				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 Bauernschmidt Drive Baltimore Md. 21221			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery		Date 5/6/96		20c. Location - City or Town, State BALTIMORE Md.	
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Maryland 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous carcinoma of the lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 8 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 2 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James Orford (MD)		29c. License number D46163		29d. Date signed (Month, Day, Year) 05/02/1996 May 2, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James Orford 9000 Franklin Square Drive Baltimore, MD 21237							
31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature Julia Thornton-Pendall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-6111.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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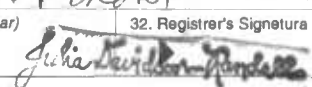
1965  
1966  
1967

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13077

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ETHLIN E. PALMER</b>		2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>8:45 am</b>
	4a. Facility Name (If not institution, give street and number) <b>2934 Harford Road</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-88-4975</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jul. 19, 1921</b>		9. Birthplace (State or Foreign Country) <b>Jamaica</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>4803 Lorelly Avenue Apt. 2A</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Jamaican</b>
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeper</b>		16b. Kind of Business/Industry <b>Goetz Candy Co.</b>
	17. Father's Name (First, Middle, Last) <b>Octavious Beckford</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eda Campbell</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Olive Stewart</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2738 Tivoly Ave., Baltimore, MD 21218</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>5-4-96</b>
	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Baltimore, MD 21202</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)				
	a. <b>CARDIO RESP ARREST</b>				<b>1h.</b>
	Due to (or as a consequence of):				
	b. <b>CA BREAST with M.C.</b>				<b>1 yr</b>
	Due to (or as a consequence of):				
	c. <b>40 + BP</b>				<b>50 yr</b>
	Due to (or as a consequence of):				
	d.				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D14241</b>		29d. Date signed (Month, Day, Year) <b>5.1.86</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. A. Arkow 2236. Blum Bldg apt 2122</b>					
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar





96 13078

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SARAH P. PAGE</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>1</b> YEAR <b>96</b>		3. TIME OF DEATH <b>9:30</b> M	
4. SOCIAL SECURITY NUMBER <b>242-12-0574</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/21/16</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>LORAIN FRANKFORD</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8c. COUNTY OF DEATH <b>—</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10 Elm Drive</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>William Cole &amp; Sons</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Luther Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Page</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Elm Drive Baltimore Md 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 5/4/96</b>		20c. LOCATION — City or Town, State <b>Rossville Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CHRONIC CACHEXIA / DEBILITATION</b>							
c. <b>ADVANCED ALZHEIMERS</b>							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPOTHYROID, HTN, MI, PUD, CIA, X-Smoker</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D41291</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JONATHAN GITTER, MD. 21 CROSSROADS DR. #330 GWINES HILLS, MD. 21117</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13079

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Pietruska</b>				2. Date of Death Month <b>May</b> , Day <b>1</b> , Year <b>1996</b>		3. Time of Death <b>12:30 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1205 East Homberg Avenue</b>				4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore Co.</b>	
Funeral Director	5. Social Security Number <b>212-01-9149</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 30, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>Poland</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1205 East Homberg Avenue</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Container Company</b>		
17. Father's Name (First, Middle, Last) <b>Paul Pietruska</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Buczinski</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Riessler (SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>353 Oberle Ave. Essex, Maryland 21221</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart Of Jesus Cemetery</b>		20c. Location - City or Town, State <b>Baltimore Co., Md.</b>				
21. Signature of Funeral Service Liaison <i>[Signature]</i>				22. Name and Address of Facility <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>[Signature]</i> Due to (or as a consequence of): b. <i>[Signature]</i> Due to (or as a consequence of): c. <i>[Signature]</i> Due to (or as a consequence of): d. <i>[Signature]</i>								Approximate Interval Between Onset and Death  <i>16.</i>  <i>10yr</i>  <i>5+yr</i>  <i>5yr</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D14221</b>		29d. Date signed (Month, Day, Year) <b>5-1-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. A. Peltor 223 B. Rose Road and 21221</b>								
31. Date filed (Month, Day, Year) - <b>MAY 03 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13080

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DARTANYON ROBINSON</b>					2. Date of Death Month Day Year <b>MAY 01, 1996</b>		3. Time of Death <b>11:00 a.m.</b>		
	4a. Facility Name (If not Institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>n/a</b>		
<b>Funeral Director</b>	5. Social Security Number <b>217-68-0302</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>38</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP. 28, 1957</b>		9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5603 THE ALAMEDA</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>UNITED STATES</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th</b> Collega (1-4or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>self employed</b>			
17. Father's Name (First, Middle, Last) <b>CURTIS STOKES</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>JANICE BALLARD</b>					
19a. Informant's Name/Relationship (Type, Print) <b>JANICE BAKER</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5603 THE ALAMEDA APT. D, BALTIMORE, MD #39</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEM. 5-6</b>		Data		20c. Location - City or Town, State <b>LANSDOWNE, MD</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>WM. C. MARCHFH.-1101 E. NORTH AVENUE</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Cytomegaloviral pneumonitis</b> Due to (or as a consequence of):										one month
b. <b>Pneumocystis carinii pneumonia</b> Due to (or as a consequence of):										two months
c. <b>Acquired Immune Depression Syndrome</b> Due to (or as a consequence of):										two years
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <b>Mark Lewis MA</b>		29c. License number <b>M6321</b>		29d. Date signed (Month, Day, Year) <b>May 1, 1996</b>	
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>Mark Lewis Johns Hopkins Hospital, Baltimore, Maryland</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**State  
Registrar**

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13081

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Rosemarie Robinson</b>				2. Date of Death Month <b>April</b> Day <b>30</b> Year <b>96</b>		3. Time of Death <b>8 45 AM</b>				
4a. Facility Name (If not institution, give street and number) <b>3903 Chatham Rd.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>				
5. Social Security Number <b>219-30-2324</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year)				
Usual Residence of Decedent				9. Birthplace (State or Foreign Country) <b>MD.</b>						
10a. State <b>MD.</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>3903 Chatman</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (14 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Social Club</b>				
17. Father's Name (First, Middle, Last) <b>Frederick A. Scott</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith M. Scott</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Robert L. Robinson Jr - son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3905 Chatham Rd. BALTIMORE, MD. 21207</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem Park</b>		20c. Date <b>5-4-96</b>		20d. Location - City or Town, State <b>Randallstown, MD.</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie F/H PA 638 N. Gilmer St. 21217</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): a. <b>coronary artery disease</b> b. <b>HTN</b> c. <b>stroke</b> d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  <table border="1"> <tr> <td><b>&gt; 1 yr</b></td> </tr> <tr> <td><b>&gt; 1 yr</b></td> </tr> <tr> <td><b>&gt; 1 yr</b></td> </tr> </table>								<b>&gt; 1 yr</b>	<b>&gt; 1 yr</b>	<b>&gt; 1 yr</b>
<b>&gt; 1 yr</b>										
<b>&gt; 1 yr</b>										
<b>&gt; 1 yr</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>AS 240 2321 VL 9833</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Vincent Lee / Sinai Hospital 2401 W. Belvedere, Balt. MD 21215</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 13082

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ann E REDMOND</i>				2. DATE OF DEATH MONTH <i>MAY</i> DAY <i>7</i> YEAR <i>96</i>		3. TIME OF DEATH <i>1:05 A M</i>	
4. SOCIAL SECURITY NUMBER <i>214-24-7992</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 5, 1914</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>							
9a. FACILITY NAME (If not institution, give street and number) <i>Chesapeake Health Care</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Arnold</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Pikesville</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7017 Alden Road</i>				10f. ZIP CODE <i>21208</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (9-12)</i> <i>12</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Dr. David Lazerow</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Charles E. Lenderking</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Etta Reid</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. James Redmond, III</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2060 Clearview Drive Owings, MD 20736</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Entombment</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Druid Ridge Mausoleum May 4</i>		20c. LOCATION — City or Town, State <i>Pikesville, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M Jenkins</i>				22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension - borderline</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>1 Hour</i> <i>AT LEAST 5 YEARS</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>RL Scott Edm, MD</i>				29c. LICENSE NUMBER <i>D30701</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/1/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R. SCOTT EDEN, MD, 100 RIDGELY AVE, ANNAPOLIS, MD 21401</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 03 1996</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13083

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marshall R. Russell

2. Date of Death

April 21, 1996

3. Time of Death

22:55

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

220-14-6586

6. Sex

M 2 F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

If Under 24 Hrs.

Min.

8. Date of Birth

Oct 10, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3605 Parkdale Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Fork Lift Operator

16b. Kind of Business/Industry

Liquor Company

17. Father's Name (First, Middle, Last)

Marshall Russell

18. Mother's Name (First, Middle, Maiden Surname)

Cara Balderstall

19a. Informant's Name/Relationship (Type, Print)

Rosella Russell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 Parkdale Avenue, Baltimore, Maryland 21211

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Memorial

Data

4/25

20c. Location - City or Town, State

Cockeysville, Maryland

21. Signature of Funeral Service Licensee

Jenny Hens Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home 21211

3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Pulmonary Embolism  
Due to (or as a consequence of):b. Peripheral Vascular Disease  
Due to (or as a consequence of):c. Diabetes Mellitus  
Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending

Investigation

6 Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John P. Hill, MD

29c. License number

D-41699

29d. Date signed (Month, Day, Year)

April, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. HILL

UNION MEMORIAL HOSPITAL BALTO, MD 21218

31. Date filed (Month, Day, Year)

MAY 03 1996

Registrar's Signature

John P. Hill

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13084

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ann Brodtkin Reamer				2. Date of Death Month Day Year April 26 1996				3. Time of Death 10:00am	
	4a. Facility Name (If not Institution, give street and number) 3310 N. Leisure World Blvd.				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 219-01-3853		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		8. Date of Birth (Month, Day, Year) Aug. 3, 1918		9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10e. Street and Number 3310 N. Leisure World Blvd.				10f. Zip Code 20908				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) -12-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Isaac Brodtkin				18. Mother's Name (First, Middle, Maiden Summa) Fanny Saidman					
	19e. Informant's Name/Relationship (Type, Print) Beverly Ludwig/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Memory Ct. Silver Spring, Md. 20904					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery				20c. Location - City or Town, State 4/28 Adelphi, Md.	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility IVES-PEARSON FUNERAL HOMES FALLS CHURCH, VA. 22046					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 Day	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probable Carcinoma of Lung								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
					28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number PO 4775				29d. Date signed (Month, Day, Year) 4-26-96	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave. #304 Silver Spring, Md. 20902				31. Data filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature Julia Wilson	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13085

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <p align="center">Doris E. Ross</p>					2. Date of Death Month Day Year May 1, 1996		3. Time of Death 4:50 pm		
	4a. Facility Name (If not institution, give street and number) <p align="center">1022 West 38th Street</p>					4b. City, Town, or Location of Death <p align="center">Baltimore</p>		4c. County of Death <p align="center">N/A</p>		
<b>Funeral Director</b>	5. Social Security Number 213-03-3316		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Aug 23, 1920		9. Birthplace (State or Foreign Country) Balto, MD	
	Usual Residence of Decedent									
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1022 West 38th Street					10f. Zip Code 21211		10g. Citizen of What Country? U.S.A			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Charles W. Frank					18. Mother's Name (First, Middle, Maiden Surname) Charlotte K. Smith					
19a. Informant's Name/Relationship (Type, Print) Thomas Ross (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 West 38th Street, Baltimore, Maryland 21211					
20a. Method of Disposition X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem		Date 5/3/96		20c. Location - City or Town, State Owings Mills, Md			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md. 21211					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): a. CARDIOALMONARY + RESPIRATORY ARREST b. MYOCARDIAL HEART DISEASE Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d. CONGESTIVE HEART FAILURE  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown QNT 1986 (60 pack)										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INJURY DUE TO HEART DISEASE (MURDER)										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) X <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D35085		29d. Date signed (Month, Day, Year) 5/2/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN LEVITT MD 861 PARK AVENUE BALTIMORE, MD 21201										
31. Date filed (Month, Day, Year) MAY 03 1996			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Rubie Somerville Fortune Somerville</i>				2. DATE OF DEATH MONTH DAY YEAR <i>APRIL 25 1996</i>		3. TIME OF DEATH <i>9:17 PM</i>	
4. SOCIAL SECURITY NUMBER <i>219-10-8696</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 18, 1927</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Union Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1727 E. 32nd Street</i>			
10f. ZIP CODE <i>21218</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+) <i>—</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Edward Allen Thomas</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Florence Mae Fletcher</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Bernice Fortune</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2057 BobHendrickson Ct., Baltimore, MD 21237</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park 5-3-96 Arbutus, Maryland</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Symette K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <i>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>COPD EXACERBATION</i> Due to (or as a consequence of): <i>SEPSIS</i> Due to (or as a consequence of): <i>BACTEREMIA</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>1 WEEK</i> <i>1 WEEK</i> <i>1 WEEK</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>A. FIB, HYPERTENSION, NIDDM, CHF</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eleanor McGuzman MD</i>				29c. LICENSE NUMBER <i>AT 2438946</i>		29d. DATE SIGNED (Month, Day, Year) <i>APRIL 25, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ELEANOR MCGUZMAN, MD, DEPT. OF MEDICINE, UMH, BALTIMORE, MD 21218</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 03 1996</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13087

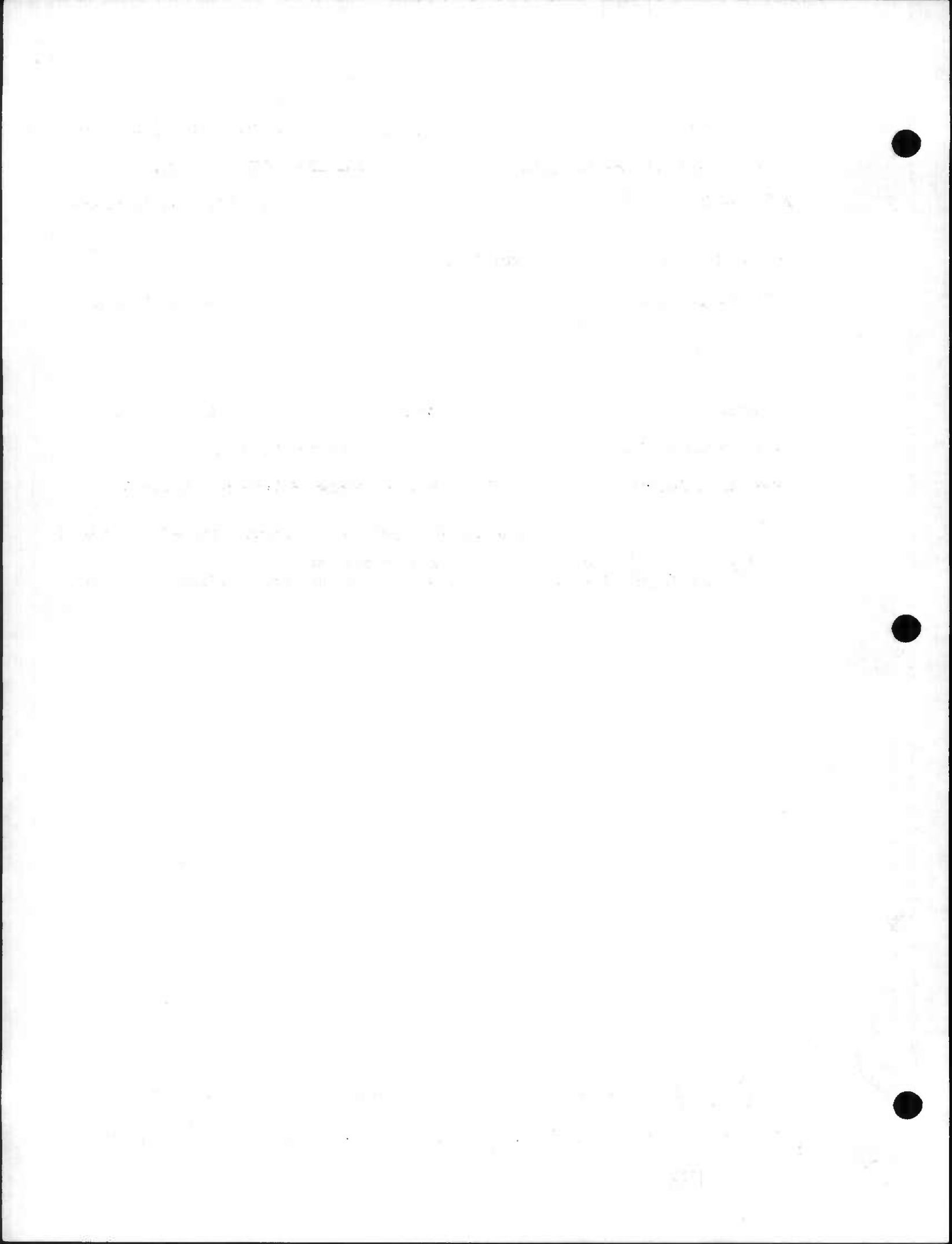
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEON SPENCER Jr.</b>				2. Date of Death Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>03:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-72-0038</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 16, 1959</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (14 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Burger King</b>		17. Father's Name (First, Middle, Last) <b>Leon Spencer, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marion L. Washington</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Marion L. Spencer</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1619 Rutland Avenue, Baltimore, MD 21213</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>5/3/96 Dundalk, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Baltimore, MD 21202</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>AIDS</b> Due to (or as a consequence of): c. <b>HIV</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>5 days</b> <b>2 years</b> <b>10 years</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Adrenal Insufficiency</b> <b>GI Bleeding</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number <b>M9065</b>		29d. Date signed (Month, Day, Year) <b>April 28, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Chin Hur 110 Tower Building, Johns Hopkins Hospital, Baltimore MD 21287</b>		31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13088

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nicey Shipmon</b>				2. Date of Death Month Day Year <b>May 7, 1996</b>		3. Time of Death <b>11:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mercy Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>248-28-5021</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 28, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>South Carolina</b>							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Columbia</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>5430 Old Waterloo Rd.</b>				10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Israel McElveen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Missiour McElveen</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Winnie Cann</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8323 Mindell Circle St. Balto. Md. 21244</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakeview Cemetery</b>		20c. Location - City or Town, State <b>5/6/96 Sykesville, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
	23a. Part I. Enter the disease, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b> Due to (or as a consequence of): <b>Atherosclerotic Vascular Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> <b>Renal Failure</b> <b>Hypertension</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D38675</b>		29d. Date signed (Month, Day, Year) <b>5/12/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <b>John Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Items: 23 PART I, II, 27,  
PER MEO FILM G-735 5/15/96 t.t  
Item 1, Film 735, 5/3/96, 1t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13089

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM HENRY

STEWART  
STEWART

2. Date of Death

Month Day Year  
MAY 2 1996

3. Time of Death

04:47 AM

4a. Facility Name (If not institution, give street and number)

3810 DOLFIELD AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

230-60-5477

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 21, 1950

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3810 Dolfield Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

N/A

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Groom

18b. Kind of Business/Industry

Race Track

17. Father's Name (First, Middle, Last)

William Stewart, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Hatcher

19a. Informant's Name/Relationship (Type, Print)

Gladys Moore- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

135 Rockwell Avenue Apt 39 Long Branch, N. J. 07740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

5-3-96

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

Jerome A. Thompson

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
8 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MILTON E. STOKES JR.</b>					2. Date of Death Month <b>MAY</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>9:50AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>IN FRONT OF 4226 CRAWFORD AVENUE</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NIA</b>		
<b>Funeral Director</b>	5. Social Security Number <b>215-22-1477</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 29, 1927</b>		9. Birthplace (State or Foreign Country) <b>md</b>	
	Usual Residence of Decedent									
<b>To Be Completed by Funeral Director</b>	10a. State <b>md</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>Balto</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>4226 Crawford Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>6/21/46 thru 11/18/47</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>NIA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Payroll Clerk</b>		16b. Kind of Business/Industry <b>U.S. Postal Service</b>			
	17. Father's Name (First, Middle, Last) <b>Milton E. Stokes</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Carter</b>				
<b>Physician /Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Annie Stokes - wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4226 Crawford Ave Balto, md 21215</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		Date <b>5/1/96</b>		20c. Location - City or Town, State <b>Owings Mills, md</b>		
	21. Signature of Funeral Service Licensee <b>Helen March</b>					22. Name and Address of Facility <b>March FH-west 4300 Wabash Ave</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. INTRAORAL GUNSHOT WOUND</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARCINOMA OF PROSTATE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <b>PARTIAL</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>IN CAR</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>5/1/1996</b>		28b. Time of Injury <b>8:30AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SELF-INFLICTED GUNSHOT WOUND</b>	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>DRIVEWAY IN CAR</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4226 CRAWFORD AVENUE BALTIMORE, MARYLAND</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>Haysite One Yell</b>			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>			32. Registrar's Signature <b>Johanna Davis</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f allow any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13091

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret M. Stierwalt

2. Date of Death

Month Day Year  
April 27, 1996

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

265-64-1369

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 28, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3939 Roland Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Thomas Ginnerman

18. Mother's Name (First, Middle, Maiden Surname)

Laura Grove

19a. Informant's Name/Relationship (Type, Print)

Dorothy Bellamy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1612 E. Madison Avenue Baltimore, Maryland 21205

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Co.

Date

4/30/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

*Dorothy Bellamy*

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, Maryland 21211

23a. Pertinent diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION, ACUTE

Due to (or as a consequence of):

b. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA DUE TO MULTIPLE FACTORS  
CHRONIC GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N.A.

28b. Time of Injury

N.A.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N.A.

28d. Describe how injury occurred

N.A.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N.A.

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Donato A. Vargas* M.D.

29c. License number

017148

29d. Date signed (Month, Day, Year)

4-29-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donato A. Vargas 4706 Harford Road Baltimore, Maryland 21214

31. Date (Month, Day, Year)

MAY 03 1996

*Donato A. Vargas*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

96-2243-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f,

State of Maryland / Department of Health and Mental Hygiene

96 13092

PER MEO FILM G-735 5/9/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARL ANTHONY TAYLOR</b>						2. Date of Death Month <b>APRIL</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>10:30 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>2112 DIVISION STREET</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-84-9638</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>35</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1960</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>8315 LINDALE Circle, Apt. A</b>				10f. Zip Code <b>21207 21244</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BRIDGE Construction Worker</b>			16b. Kind of Business/Industry <b>WAGMAN INC. Construction</b>		
	17. Father's Name (First, Middle, Last) <b>Lewis W. Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie B. Brown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lewis Taylor, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3334 Ravenwood Avenue, Baltimore, MD 21213</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>5-3-96</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>			
	21. Signature of Funeral Service Licensee <i>Thymette K. Jones</i>				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>NARCOTIC AND ALCOHOL INTOXICATION</b> e. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>4/25/96</b>		28b. Time of Injury <b>10:17 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOUSE</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2112 DIVISION ST.</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Donald G Wright MD</i>				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>APRIL 26, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DONALD G WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>										
32. Registrar's Signature <i>John Davidson-Randall</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13093

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILBERT TRENT</b>				2. Date of Death Month Day Year <b>APRIL 25 1996</b>		3. Time of Death <b>9:41A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTO. CITY</b>		
Funeral Director	5. Social Security Number <b>095-42-2159</b>		6. Sex <b>100 M 200 F</b>	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4-6-1952</b>	9. Birthplace (State or Foreign Country) <b>N.Y.</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>BALTO. CITY</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <b>100 Yes 200 No</b>			
	10e. Street and Number <b>1100 BOLTON STREET APT. 509</b>			10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <b>100 Never Married 200 Married</b> <b>300 Widowed 400 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>100 Yes 200 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>100 Yes 200 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: AFR. AMERICAN</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMMUNICATION (STUDENT)</b>		16b. Kind of Business/Industry <b>COLLEGE</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>ANDREW TRENT</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>NAOMI TRENT</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>NAOMI TRENT (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1100 BOLTON STREET BALTO. MD 21201</b>				
	20a. Method of Disposition <b>100 Burial 200 Cremation 300 Removal from State 400 Donation 500 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEM. 4/30/1996</b>		20c. Location - City or Town, State <b>CATONSVILLE MD</b>		21. Signature of Funeral Service Licensee		
	22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD 21217</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>100 Yes 200 No 300 Probably 400 Unknown</b>			
24a. Was an autopsy performed? <b>INSPECTION 100 Yes 200 No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>100 Yes 200 No</b>			
25. Was case referred to medical examiner? <b>100 Yes 200 No</b>		28. Place of Death (Check only one) Hospital: <b>100 Inpatient 200 ER/Outpatient 300 DOA</b> Other: <b>400 Nursing Home 500 Residence 800 Other (Specify)</b>							
27. Manner of Death <b>100 Natural 200 Accident 300 Suicide 400 Homicide</b> <b>500 Pending investigation 600 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>100 Yes 200 No</b>		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>200 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier <b>Theodore M. King M.D.</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 25, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>J. A. Davidson-Randall</b>							





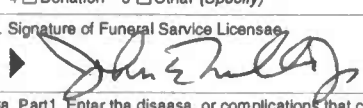
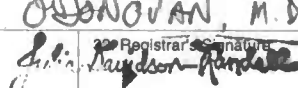
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13094

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY EDWARD TISDALE</b>				2. Date of Death Month Day Year <b>APRIL 26 1996</b>		3. Time of Death <b>7:30PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>3119 SUMMIT AVE.</b>				4b. City, Town, or Location of Death <b>CARNEY</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>265-34-7624</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 24, 1930</b>	9. Birthplace (State or Foreign Country) <b>FLORIDA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>CARNEY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3119 SUMMIT AVE</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b> College (1-4 or 5+) <b>5+ YRS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRONICS ENGINEER</b>		16b. Kind of Business/Industry <b>BENDIX RADIO</b>			
17. Father's Name (First, Middle, Last) <b>GEORGE GRESHAM TISDALE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVELYN EWING</b>				
19a. Informant's Name/Relationship (Type, Print) <b>GWENDOLYN TISDALE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3119 SUMMIT AVE CARNEY MD 21234</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENMOUNT CREMATORY</b>		Data <b>4/29</b>		20c. Location - City or Town, State <b>BALTIMORE</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARBOR RD. 21234</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Chronic congestive heart failure</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Crossan Donovan</b>		29c. License number <b>DO 7632</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Crossan Donovan, M.D., 2112 DUNDALK AVE., BALTO MD 21222</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13095

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARENCE H WILLIAMSON Jr.		2. Date of Death APRIL 28 Day 1996 Year		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) 291 EAST PULASKI HIGHWAY		4b. City, Town, or Location of Death ELKTON		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 199-18-9950		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.	
	8. Date of Birth (Month, Day, Year) Aug. 14, 1928		9. Birthplace (State or Foreign Country) S. Carolina		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State S.C.		10b. County n/a	
	10c. City, Town or Location Holly Hill		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 147 Garrett Road	
	10f. Zip Code 29059		10g. Citizen of What Country? United States		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Army National Guard	
	17. Father's Name (First, Middle, Last) Clarence Williamson. Sr.		18. Mother's Name (First, Middle, Maiden Surname) Etheline Dessaure		19a. Informant's Name/Relationship (Type, Print) Zelda Roberts	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Vance, South Carolina 29163		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Jerusalem Cemetery	
	20c. Location - City or Town, State Holly Hills, S.C.		21. Signature of Funeral Service Licensee <i>Signette K. Jones</i>		22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <i>Partial</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	b. Due to (or as a consequence of):		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. Due to (or as a consequence of):		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
d. Due to (or as a consequence of):		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		
29d. Date signed (Month, Day, Year) APRIL 29, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201		31. Data filed (Month, Day, Year) MAY 03 1996		
32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

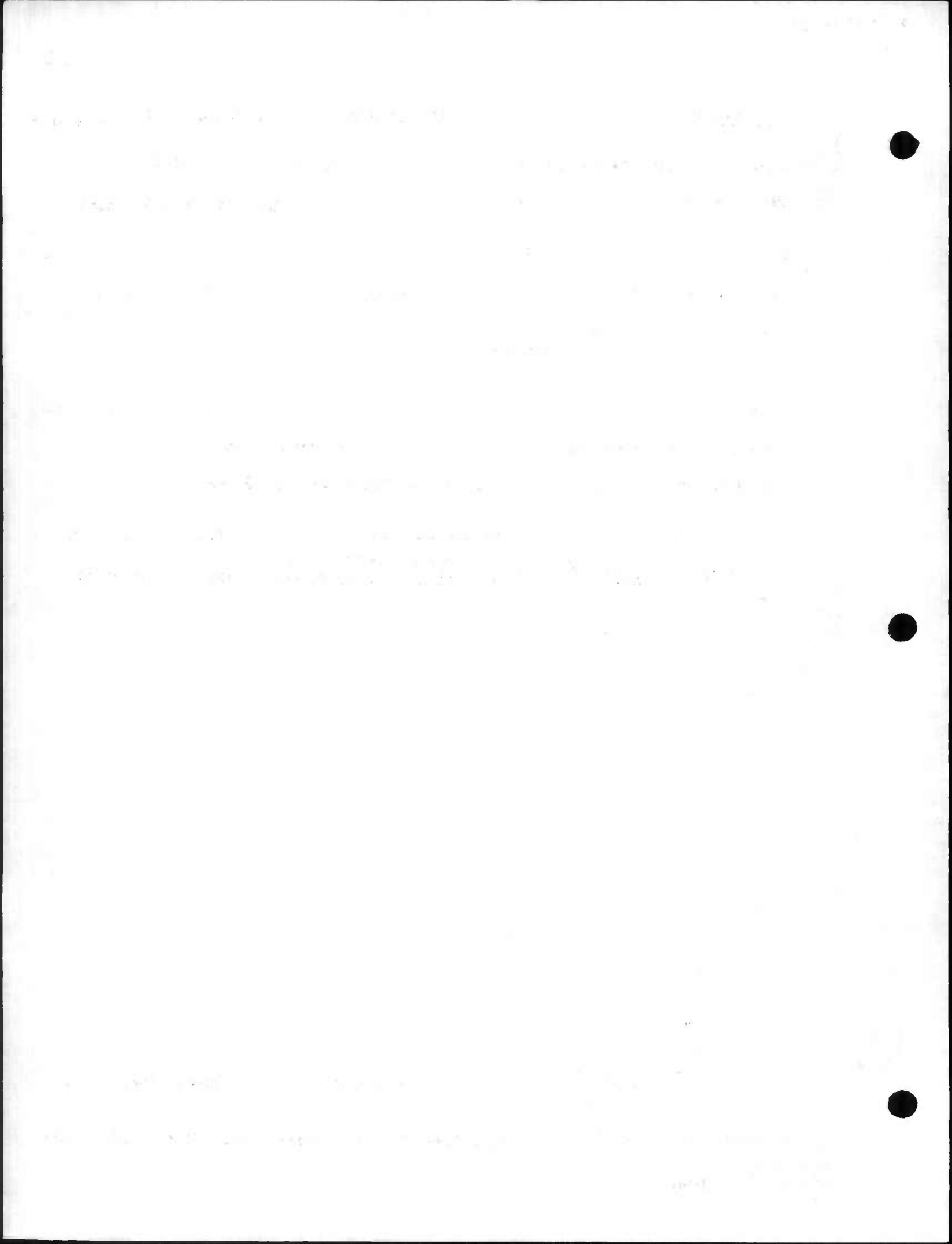
Physician  
/Medical  
Examiner

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13096

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTYE JEAN WILSON				2. Date of Death Month MAY Day 1 Year 96		3. Time of Death 9:30 pm	
	4a. Facility Name (If not institution, give street and number) Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 241-62-7456	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State md	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1206 Wildwood Pkwy			10f. Zip Code 21229		10g. Citizen of What Country? U.S.A		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Technician		16b. Kind of Business/Industry Hospital			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Jonah C. Hinnant				18. Mother's Name (First, Middle, Maiden Surname) Iona Daniels			
	19a. Informant's Name/Relationship (Type, Print) Denise Wilson-Lewis-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Wildwood Pkwy Baltimore, md 21229			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Pk		20c. Date 5/4/96		20d. Location - City or Town, State Randallstown, md	
	21. Signature of Funeral Service Licensee Thorne A. Thompson		22. Name and Address of Facility March F.H. West 4300 Wabash Ave					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. GLOBULSTOMA Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death ~10 mos.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Stella maris at mercy Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Thorne A. Thompson		29c. License number D40480		29d. Date signed (Month, Day, Year) MAY 2, 1996			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FERNANDO J. FERRO, MD 5810 BELAIR RD. BALD., MD 21206							
	31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature John A. Wilson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death at the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13097

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM WARD</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>				3. Time of Death <b>7:45 P.M.</b>																																	
	4a. Facility Name (If not institution, give street and number) <b>ST AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>																																	
Funeral Director	5. Social Security Number <b>213-10-5895</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 4, 1918</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>																																	
	10a. State <b>MARYLAND</b>				10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																	
To Be Completed by Funeral Director	10e. Street and Number <b>514 MAIDEN CHOICE LANE</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>																																			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																																			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College (1-4or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>AUTOMOBILE MECHANIC</b>				16b. Kind of Business/Industry <b>AUTOMOTIVE</b>																																			
	17. Father's Name (First, Middle, Last) <b>WILLIAM WARD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>REGINA MEINEKE</b>																																					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>SONIA WARD / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>514 MAIDEN CHOICE LANE, BALTIMORE, MARYLAND 21228</b>																																					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		Date <b>MAY 2, 1996</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>																																			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</b>																																					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																									
<table border="0"> <tr> <td rowspan="4">           immediate Cause (Final disease or condition resulting in death)             Respiratory Failure             Due to (or as a consequence of):            SEVERE COPD IN EXACERBATION             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td colspan="8">           a. <b>RESPIRATORY FAILURE</b>            Due to (or as a consequence of):            SEVERE COPD IN EXACERBATION            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):         </td> </tr> <tr> <td colspan="8">           b. <b>SEVERE COPD IN EXACERBATION</b>            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):         </td> </tr> <tr> <td colspan="8">           c.             Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):         </td> </tr> <tr> <td colspan="8">           d.             Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):         </td> </tr> </table>										immediate Cause (Final disease or condition resulting in death)  Respiratory Failure  Due to (or as a consequence of): SEVERE COPD IN EXACERBATION  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): SEVERE COPD IN EXACERBATION Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								b. <b>SEVERE COPD IN EXACERBATION</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								c. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
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	c. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):																																									
	d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):																																									
<table border="0"> <tr> <td colspan="6">           Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>HEART FAILURE</b> </td> <td colspan="4">           23b. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown         </td> </tr> <tr> <td colspan="6"></td> <td colspan="4">           24a. Was an autopsy performed?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> <tr> <td colspan="6"></td> <td colspan="4">           24b. Were autopsy findings available prior to completion of cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No         </td> </tr> </table>										Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEART FAILURE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
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<table border="0"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury <b>M</b></td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="3">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>										25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																								
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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13098

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Whiteley</b>				2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>7:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Alice Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>215-03-5222</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1912</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2095 Rockrose Avenue</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Presser</b>		16b. Kind of Business/Industry <b>Tailer Shop</b>		
17. Father's Name (First, Middle, Last) <b>William Henry Clayton Whiteley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Biggs</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edna Jarvis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1329 Union Avenue, Baltimore, Maryland 21211</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>5/4/96</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Jessie Henss Carpenter</i>				22. Name and Address of Facility <b>Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Cerebrovascular accident</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. <b>Gastrointestinal bleed</b> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>DJD (Degenerative Joint Disease)</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>P. Sullivan</i> M.D.				29c. License number <b>D31464</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SHOABIS A. HASHTMI 821 N. EUTAW ST APT 308 Balt. MD 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <i>Julia Jackson-Rodriguez</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

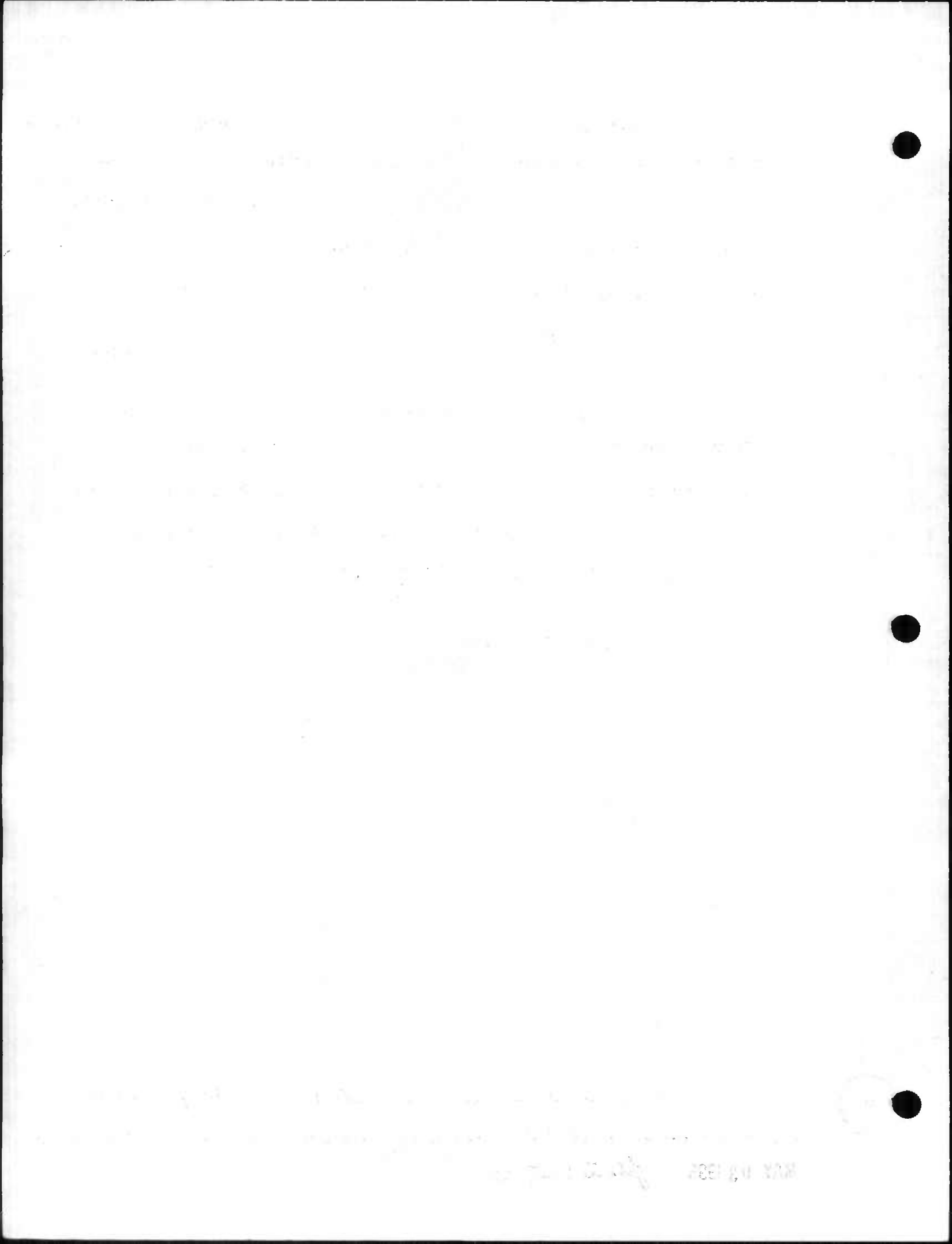
Reg. No.

56 13099

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lula Mildred Yost</b>				2. Date of Death Month Day Year <b>May 1, 1996</b>		3. Time of Death <b>11:15pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Woods Nursing Home</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>225-03-3292</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 29, 1917</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rossville</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>9200 Franklin Square Drive</b>		10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>lyr</b> College (1-4 or 5+) <b>lyr</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>US Navy</b>		17. Father's Name (First, Middle, Last) <b>George Henegar</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Hash</b>		19a. Informant's Name/Relationship (Type, Print) <b>Notral Kernes</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1608 Rickenbacker Road Baltimore Md. 21221</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 5/4/96</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>		21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>	
22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. PNEUMONIA</b> Due to (or as a consequence of): <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>		Approximate Interval Between Onset and Death <b>ONE DAY</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STROKE</b>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Carol Richardson MD</b>		29c. License number <b>D46304</b>		29d. Date signed (Month, Day, Year) <b>May 3, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CAROL RICHARDSON MD 9000 Franklin Square Drive Baltimore MD 21237</b>	
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <b>Johanna Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13100

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William E. Anderson, Sr.				2. Date of Death Month Day Year April 28, 1996		3. Time of Death 9:15PM		
	4a. Facility Name (If not institution, give street and number) Madonna Heritage Nursing Home				4b. City, Town, or Location of Death Jarrettsville		4c. County of Death Harford		
Funeral Director	5. Social Security Number 216-05-8585	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1910		9. Birthplace (State or Foreign Country) Balto.Md.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Harford	10c. City, Town or Location Jarrettsville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 3982 Norrisville Road			10f. Zip Code 21084		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th. College (1-4or 5+) 10th.		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Subcontractor		18b. Kind of Business/Industry Construction Industry				
	17. Father's Name (First, Middle, Last) Winifred Anderson				18. Mother's Name (First, Middle, Maiden Surname) Martha Richardson				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William E. Anderson, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Baldwin Mill Rd. Jarrettsville, Md. 21084				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		Date May 3, 1996		20c. Location - City or Town, State Balto.Md.		
	21. Signature of Funeral Service Licensee E. F. Lassahn		22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087						
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death)		e. Coronary Artery Disease Due to (or as a consequence of):				4 yrs		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Cerebral Vascular Accident Due to (or as a consequence of):				4 yrs			
		c. Seizure disorder 2° to b Due to (or as a consequence of):				4 yrs			
		d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PACEMAKER Heart Atrial Fibrillation						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Care FAC.							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D39889		29d. Date signed (Month, Day, Year) 4/29/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Giles W. Macphail Bel Air MD 21014									
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature John Anderson-Rodall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

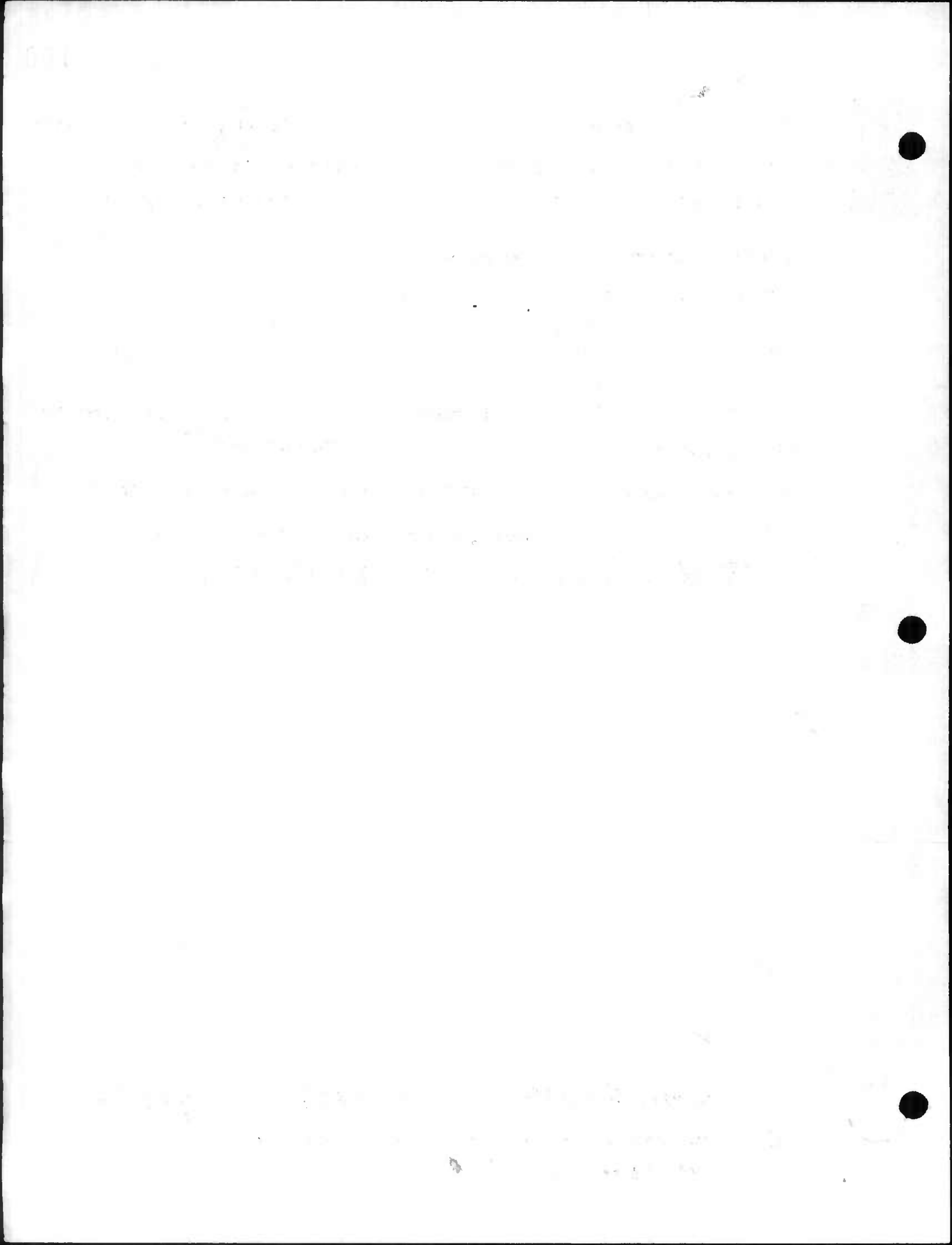
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13101

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID A. ADAMS				2. Date of Death Month Day Year APRIL 9, 1996		3. Time of Death 3:20PM	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 207-30-3192		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 5, 1934	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Delmar			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 9109 Stage Rd.				10f. Zip Code 21875		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitation Supervisor			16b. Kind of Business/Industry Poultry	
	17. Father's Name (First, Middle, Last) Milton S. Adams				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Showers			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dolores J. Adams (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9109 Stage Rd., Delmar, MD 21875			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) County Line Cemetery		Data 4/13/96		20c. Location - City or Town, State R.D. Dalmatia, PA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 10, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) APR 15 1996				32. Registrar's Signature 				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item #10a,10b,10c,10e,10f, Filing 737, 7/12/96, c/w per fh

96 13102

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THERESA ADKINS</b>		2. Date of Death Month <b>April</b> Day <b>01</b> Year <b>1996</b>		3. Time of Death <b>11 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>145-10-6059</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>August 24, 1907</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>NEW JERSEY</b>	10b. County <b>PASSAIC</b>	10c. City, Town or Location <b>Salisbury WEST MILFORD</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>300 Lemmon Hill Rd.</b>		10f. Zip Code <b>07480</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>E.I. DuPont Chemical</b>		
	17. Father's Name (First, Middle, Last) <b>August Spengler</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Kristine Gallo</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53 E. Park Dr., West Milford, NJ 07480</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ The King</b>		20c. Location - City or Town, State <b>Franklin Lakes, NJ</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>		
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>a. angiosarcoma head</b>				<b>2 months</b>
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cerebrovascular accident</b> <b>dementia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D30853</b>		29d. Date signed (Month, Day, Year) <b>4/1/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Charles B. Silvia Jr. MD PRMC 100 E CARROLL ST. SALISBURY MD 21801</b>					
31. Date filed (Month, Day, Year) <b>APR 02 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13103

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES ADKINS</b>				2. Date of Death Month Day Year <b>MARCH 29 1996</b>				3. Time of Death <b>3:22 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SALISBURY CENTER, GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>				4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>220-09-1821</b>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 31, 1912</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>104 Vanburen St.</b>				10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>George Donoway</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Nibblett Donoway</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Jacqueline Hearn</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Vanburen St. Salisbury, Md. 21804</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>		Date <b>4-2-96</b>		20c. Location - City or Town, State <b>Hebron, Md.</b>			
	21. Signature of Funeral Service Licensee <i>William M. Shortz</i>				22. Name and Address of Facility <b>Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Renal failure</i> Due to (or as a consequence of): <i>arteriosclerotic disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Approximate Interval Between Onset and Death <i>yes.</i> <i>yes.</i>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>W. Shortz</i>				29c. License number <b>D-29349</b>		29d. Date signed (Month, Day, Year) <b>5/29/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, Md. z</b>										
31. Date filed (Month, Day, Year) <b>APR 01 1996</b> 32. Registrar's Signature <i>John Davidson Randall</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner




State  
Registrar



96 13104

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Floyd William Bishop</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1996</b>		3. TIME OF DEATH <b>10:15 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-8300</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 5, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>239 Mulberry Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Washington</b>	
10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>239 Mulberry Street</b>	
10f. ZIP CODE <b>21740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Blender</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Certain-Teed Products</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Edward Bishop</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mary Bishop</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Ann Bishop</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>239 Mulberry Street Hagerstown, MD 21740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Black Oak Mennonite Cem. 4/23/96</b>		20c. LOCATION — City or Town, State <b>Warfordsburg, PA</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>Grove Funeral Home</b>		P.O. Box 368 Hancock, MD 21750					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>lung cancer</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>lung cancer</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>3 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asbestosis</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D46473</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Hind Hamdan MD 363 S. Cleveland Ave. #201 Hagerstown MD 21740</b>							
31. DATE FILED (Month, Day, Year) <b>APR 30 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


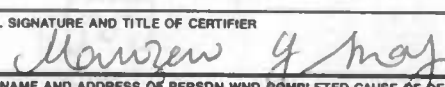
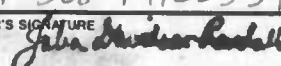
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13105

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Haskell Harman BELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1996</b>		3. TIME OF DEATH <b>5:10 a. M</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-7296</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F <b>73</b> YRS.		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 23, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Colton Villa Nursing Home</b>			
9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>				9c. COUNTY OF DEATH <b>Washington</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>941 Noland Drive</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>sales representative</b>		16b. KIND OF BUSINESS/INDUSTRY <b>railway</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Guy Harman Bell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Paugh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Katye S. Bell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>941 Noland Drive, Hagerstown, Maryland 21740</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery 4-25-96</b>		DATE <b>4-25-96</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.</b>					Approximate Interval Between Onset and Death <b>24 YRS</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>INSULIN DEPENDENT DIABETES</b>					<b>5 YRS. APP.</b>
		c. <b>PARKINSONS DISEASE</b>					<b>5 YRS. APP.</b>
		d. <b>RENAL FAILURE</b>					<b>2 YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>none</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>N/A</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D28365</b>		29d. DATE SIGNED (Month, Day, Year) <b>4.22.96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Manzar, J. SHAH 368 MILLS STREET HAGERSTOWN MD 21740</b>							
31. DATE FILED (Month, Day, Year) <b>4-22-96</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located near the bottom center of the page.



96 13106

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine G. Baker				2. DATE OF DEATH MONTH DAY YEAR April 23, 1996		3. TIME OF DEATH 0900 M	
4. SOCIAL SECURITY NUMBER 219-14-8016		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) September 26, 1916		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 19301 Smallwood Terrace				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19301 Smallwood Terrace				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16. KIND OF BUSINESS/INDUSTRY Personal residence			
17. FATHER'S NAME (First, Middle, Last) Daniel Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hoover			
19a. INFORMANT'S NAME (Type/Print) David K. Poole				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 W. Washington Street Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery April 26, 1996		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David K. Poole</i>				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Md. 21742			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 14YR</u>					
		b. <u>HYPERTENSION</u>					
		c. <u>X</u>					
		d. <u>X</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>none</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David K. Poole</i>				29c. LICENSE NUMBER D 28365		29d. DATE SIGNED (Month, Day, Year) 4.25.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILL STREET HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) APR 26 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13107

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jesse R Brown</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>23</b> YEAR <b>96</b>		3. TIME OF DEATH <b>4:20 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-30-9933</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 12, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Lantz, MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Frederick</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>400 N. Avenue</b>	
10f. ZIP CODE <b>21701</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Stone Mason</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Ivan M. Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alta Royer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Emma V. Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bethel Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Cascade, MD 21719</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Bowersox</b>				22. NAME AND ADDRESS OF FACILITY <b>Grove Funeral Home, Inc. 50 S. Broad ST Waynesboro, PA 17268</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Malignant Melanoma</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>Months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>TRANSITIONAL Cell Carcinoma of Bladder</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. J. M.D.</b>				29c. LICENSE NUMBER <b>D35152</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-23-96</b>	
30. NAME (AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>180 Thos Johnson Drive, Frederick, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

22

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edna N. BOWERS				2. DATE OF DEATH MONTH DAY YEAR April 23, 1996		3. TIME OF DEATH 7:45 p.m. M	
4. SOCIAL SECURITY NUMBER 214 09 4613		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEP 23 1901	
8. BIRTHPLACE (State or Foreign Country) Hagerstown, Md				9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Home, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Md		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 14014 Marsh Pike	
10f. ZIP CODE 17240				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: white				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress				16b. KIND OF BUSINESS/INDUSTRY Knitting Company			
17. FATHER'S NAME (First, Middle, Last) John S Bowers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Mae Young			
19a. INFORMANT'S NAME (Type/Print) Jackie Sheffler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chambersburg Pa 17201			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland Valley Crematorium 25 Waynesboro Pa			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Bowersop				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, Inc 505 Broad St Waynesboro Pa 17268			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D44996		29d. DATE SIGNED (Month, Day, Year) April 24, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZAFAR MALIK 20311 LAPPAN'S RD BOONSBORO MD 21713.							
31. DATE FILED (Month, Day, Year) APR 25 1996				32. REGISTRAR'S SIGNATURE John A. Bowersop			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13109

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Middle Name: Allen <b>Lenroe Brown</b>				2. Date of Death Month <b>April</b> Day <b>20</b> Year <b>96</b>		3. Time of Death <b>06:15</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>215-42-4170</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1944</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Williamsport</b>		
Usual Residence of Decedant		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>17121 Sterling Rd.</b>		10f. Zip Code <b>21795</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>		16b. Kind of Business/Industry <b>Tire Service</b>		17. Father's Name (First, Middle, Last) <b>Robert Chester Brown</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Catherine Mariah Green</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mary A. Brown</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17121 Sterling Rd. Williamsport, MD 21795</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bethel Cemetery</b>		20c. Location - City or Town, State <b>4/22 Foxville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795</b>		23a. Part I. Entering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Multisystem Organ Failure</b>		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D46844</b>		29d. Date signed (Month, Day, Year) <b>4/20/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Univ. of MD. Hospital Baltimore, MD</b>		31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 13110

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN Hester BECKETT</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>14</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>12:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-05-3910</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 15, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Berlin Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>401 Maple Avenue</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>African American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th grade</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker/Housewife</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Levin Bishop</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Davison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8128 Angelo Place - Philadelphia, PA 19153</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Baptist Church Cem. 04/20</b>		20c. LOCATION — City or Town, State <b>Snow Hill, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. Jolley</i>				22. NAME AND ADDRESS OF FACILITY <b>Jolley Memorial Chapel 1213 Jersey Road - Salisbury MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Coronary Artery Disease</b> b. <b>As a result of</b> c. <b>Age</b> d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHF. Poorly managed pulmonary embolism</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Federico G. Arthes</i>				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-14-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FEDERICO G. ARTHESE, MD 1622A OCEAN PINES BERLIN MD 21811 410-641-6363</b>							
31. DATE FILED (Month, Day, Year) <b>APR 18 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


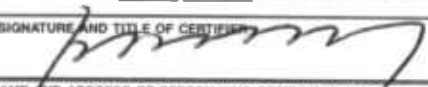
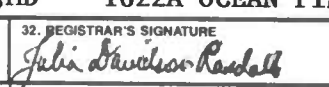
IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13111

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary ALICE Byrne</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 15 1996</b>		3. TIME OF DEATH <b>5:50p M</b>	
4. SOCIAL SECURITY NUMBER <b>212-05-0230</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>93 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 16, 1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BERLIN NURSING &amp; REHABILITATION CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BERLIN</b>		9c. COUNTY OF DEATH <b>WORCESTER</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>WORCESTER</b>		10c. CITY, TOWN OR LOCATION <b>BISHOPVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>12368 POINT VIEW ROAD</b>				10f. ZIP CODE <b>21813</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHIEF OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TELEPHONE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>PATRICK J. LEE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA NEEDHAM</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOHN B. BYRNE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12368 POINT VIEW ROAD, BISHOPVILLE, MD. 21813</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL CEMETERY 4/19/96</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>terminal pneumonia</b>					
		b. <b>Aspiration</b>					
		c. <b>Severe ASUB</b>					
		d. <b>Age</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ca of Breast</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 16 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FEDERICO G. ARTHEs, MD 1622A OCEAN PINES BERLIN, MD 21811 410-641-4400</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



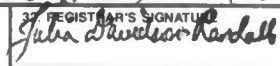
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13112

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WALTON BOZMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 4, 1996</b>		3. TIME OF DEATH <b>7:30 a m</b>	
4. SOCIAL SECURITY NUMBER <b>214-10-7529</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Parkwood II, Bldg. 1000, Apt. 204</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>Parkwood II., Bldg. 1000, Apt. 204</b>			
10f. ZIP CODE <b>21804</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Barber Supply</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Wesley Bozman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>May Horner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ronald Bozman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5525 Upper Ferry Rd., Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		DATE <b>4/8</b>		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic melanoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>1 yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30853</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/5/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles B. Silva Jr MD 100 Bow Street Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13113

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth W. BAKER</b>				2. Date of Death Month <b>April</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>4:35 a</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital @ Easton</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>221-18-0583</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/8/1909</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Talbot</b> 10c. City, Town or Location <b>Easton</b>		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Supervisor</b>		14. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4+</b>		15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail/Wholesale Agriculture Company</b>		16. Kind of Business/Industry <b>White</b>	
	17. Father's Name (First, Middle, Last) <b>Nathan T. Baker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Caroline Johnson</b>		19. Informant's Name/Relationship (Type, Print) <b>Dr. Thomas K. Baker</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 Elliott Drive - Bridgeville, DE 19933</b>	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		20c. Location - City or Town, State <b>Dover, Delaware</b>		21. Signature of Funeral Service Licensee <i>Hardesty</i>	
	22. Name and Address of Facility <b>Hardesty Funeral Home-202 Laws Street Bridgeville, DE 19933</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>Lung cancer with right pleural effusion</b> Due to (or as a consequence of): c. <b>Ac Renal failure upon chronic renal insufficiency</b> Due to (or as a consequence of): d. <b>chronic obstructive lung disease</b>		Approximate Interval Between Onset and Death <b>12 days</b> <b>3 years</b> <b>5 days</b>			
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>410 atrial fibrillation.</b> <b>4 nephrectomy 20 renal cell cancer.</b>				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <i>Syed I. Ali</i> MD		29c. License number <b>D 46020</b>		29d. Date signed (Month, Day, Year) <b>4/1/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Syed I. Ali, M.D. - 506 Idlewild Avenue - Easton, MD 21601</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>APR 03 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>					

Baltimore, Maryland 21215-0020

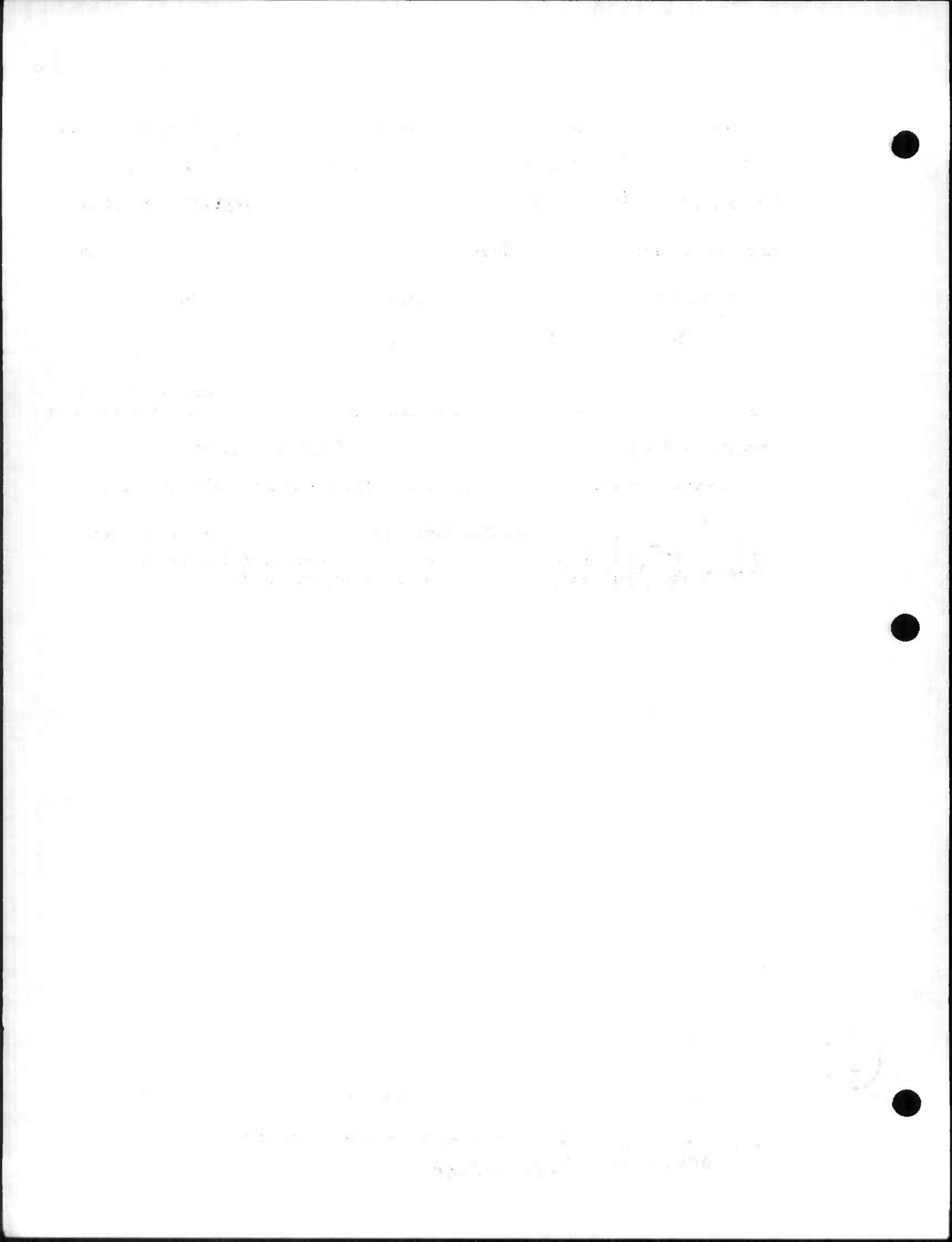
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 13114

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benjamin Joseph Butler				2. Date of Death Month Day Year April 22 1996		3. Time of Death 4:20 A.M.		
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital				4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles		
Funeral Director	5. Social Security Number 213-22-0332	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 25 1911		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Charles		10c. City, Town or Location Charlotte Hall			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 14656 Oak Road			10f. Zip Code 20622		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Collage (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farming		16b. Kind of Business/Industry Agricultural			
	17. Father's Name (First, Middle, Last) William Butler				18. Mother's Name (First, Middle, Maiden Surname) Catherine Brown Butler				
	19a. Informant's Name/Relationship (Type, Print) Mary Alice Butler (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 14656 Oak Road Charlotte Hall, MD 20622				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St Mary's Cemetery		Data 4-25-96		20c. Location - City or Town, State Bryantown, MD		
	21. Signature of Funeral Service Licensee  M00173				22. Name and Address of Facility J.H. Eberwein Mortuary 11855 Holly La #104 Waldorf, MD 20601				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Unspecified Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. Portacaval shunt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D20629		29d. Date signed (Month, Day, Year) 4/22/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) George H. Wathen MD 11345 Pembroke Square Suite 104 Waldorf, MD 20603									
31. Date filed (Month, Day, Year) APR 24 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



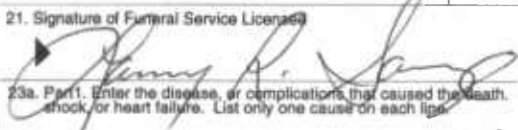
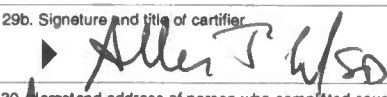
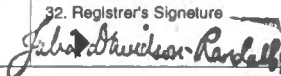
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13115

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RANDOLPH TRINKLE BALES						2. Date of Death Month Day Year April 15, 1996		3. Time of Death 7:30 P.M.																		
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick																		
Funeral Director	5. Social Security Number 219-36-2652		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.																		
	6. Date of Birth (Month, Day, Year) Dec. 2, 1914		9. Birthplace (State or Foreign Country) Virginia																								
Usual Residence of Decedent																											
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
10e. Street and Number 11530 Hessong Bridge Road				10f. Zip Code 21788				10g. Citizen of What Country? United States																			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Farming																			
17. Father's Name (First, Middle, Last) Harlowe S. Bales						18. Mother's Name (First, Middle, Maiden Surname) Ammie M. Davis																					
19a. Informant's Name/Relationship (Type, Print) James E. Bales, nephew						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11244 Putman Road Thurmont, Maryland 21788																					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		Date 4/18/96		20c. Location - City or Town, State Thurmont, Maryland																			
21. Signature of Funeral Service Licensed 						22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, MD 21788																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																											
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>CHF</td> <td>Due to (or as a consequence of):</td> <td>10 yrs</td> </tr> <tr> <td>b.</td> <td>Aortic Stenosis</td> <td>Due to (or as a consequence of):</td> <td>10 yrs</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CHF	Due to (or as a consequence of):	10 yrs	b.	Aortic Stenosis	Due to (or as a consequence of):	10 yrs	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CHF	Due to (or as a consequence of):	10 yrs																							
	b.	Aortic Stenosis	Due to (or as a consequence of):	10 yrs																							
	c.		Due to (or as a consequence of):																								
	d.		Due to (or as a consequence of):																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred																		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																											
29b. Signature and title of certifier 						29c. License number D26516		29d. Date signed (Month, Day, Year) April 16 1996																			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Allen J. Gison 1475 TAYLOR Ave FRED MD 21762																											
31. Date filed (Month, Day, Year) APR 17 1996			32. Registrar's Signature 																								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13116

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Kathryn Breedon				2. Date of Death Month April Day 12, Year 1996				3. Time of Death 9:15 a.m.					
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick					
Funeral Director	5. Social Security Number 216-22-2316		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) June 26, 1908		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 415 Banksia Drive				10f. Zip Code 21701				10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Switchboard Operator				16b. Kind of Business/Industry Telephone Operator					
	17. Father's Name (First, Middle, Last) Matthew Houston James				18. Mother's Name (First, Middle, Maiden Surname) Minnie Rosallia Williams									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lillian Morton				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19028 Warrioe Brook Dr., Germantown, MD 20874									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens				20c. Location - City or Town, State Frederick, Maryland					
	21. Signature of Funeral Service Licensee R. B. Mackay				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Probable myocardial infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last													
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoarthritis, Osteoporosis														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kathleen W Stern MD		29c. License number D32073		29d. Date signed (Month, Day, Year) 4/12/96								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kathleen W. Stern MD, 610 Ninth Ave, Brunswick, Md. 21716														
31. Date filed (Month, Day, Year) APR 17 1996		32. Registrar's Signature Ki Bruckner-Randall												

Baltimore, Maryland 21215-0020

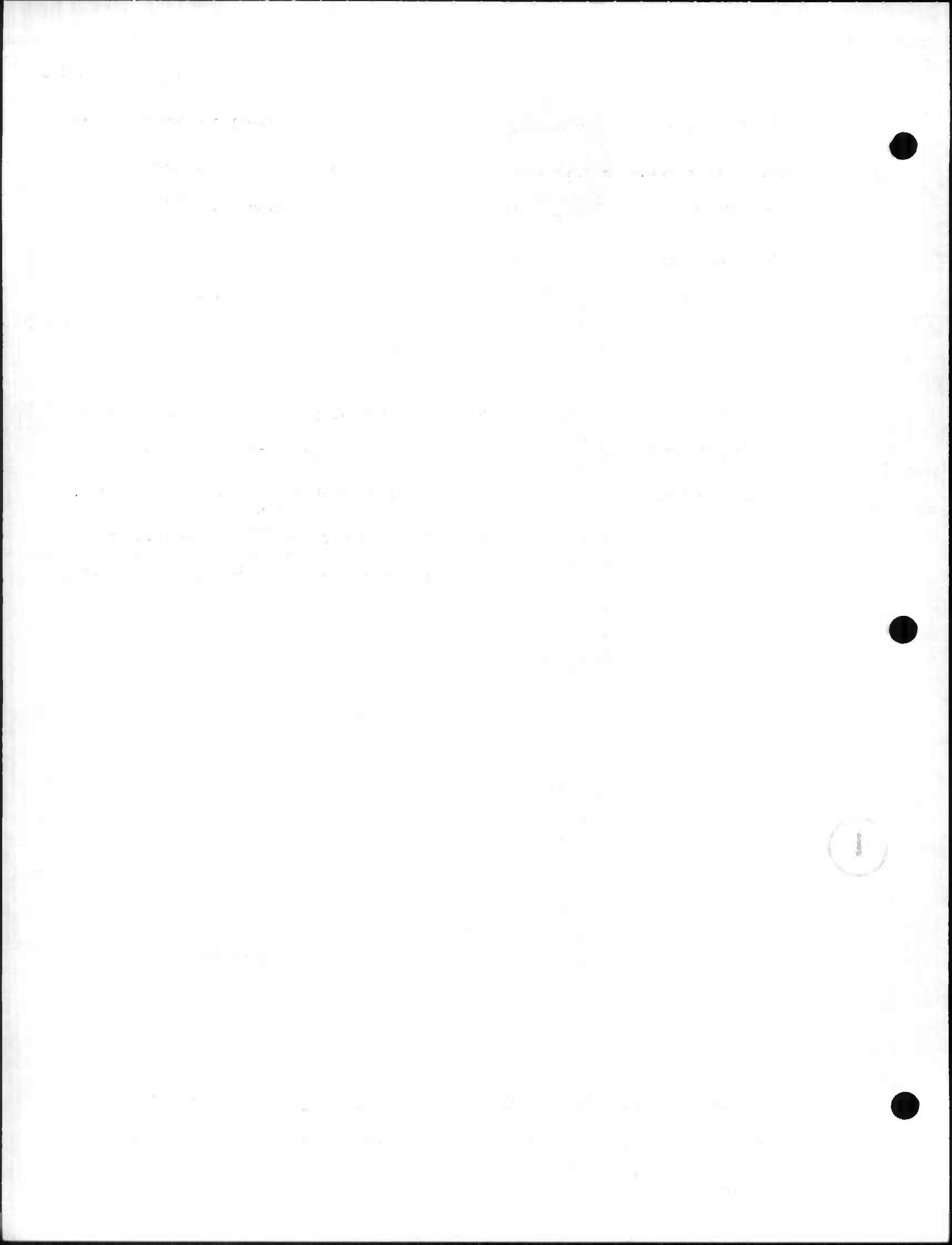
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13117

## Certificate of Death

Reg. No.

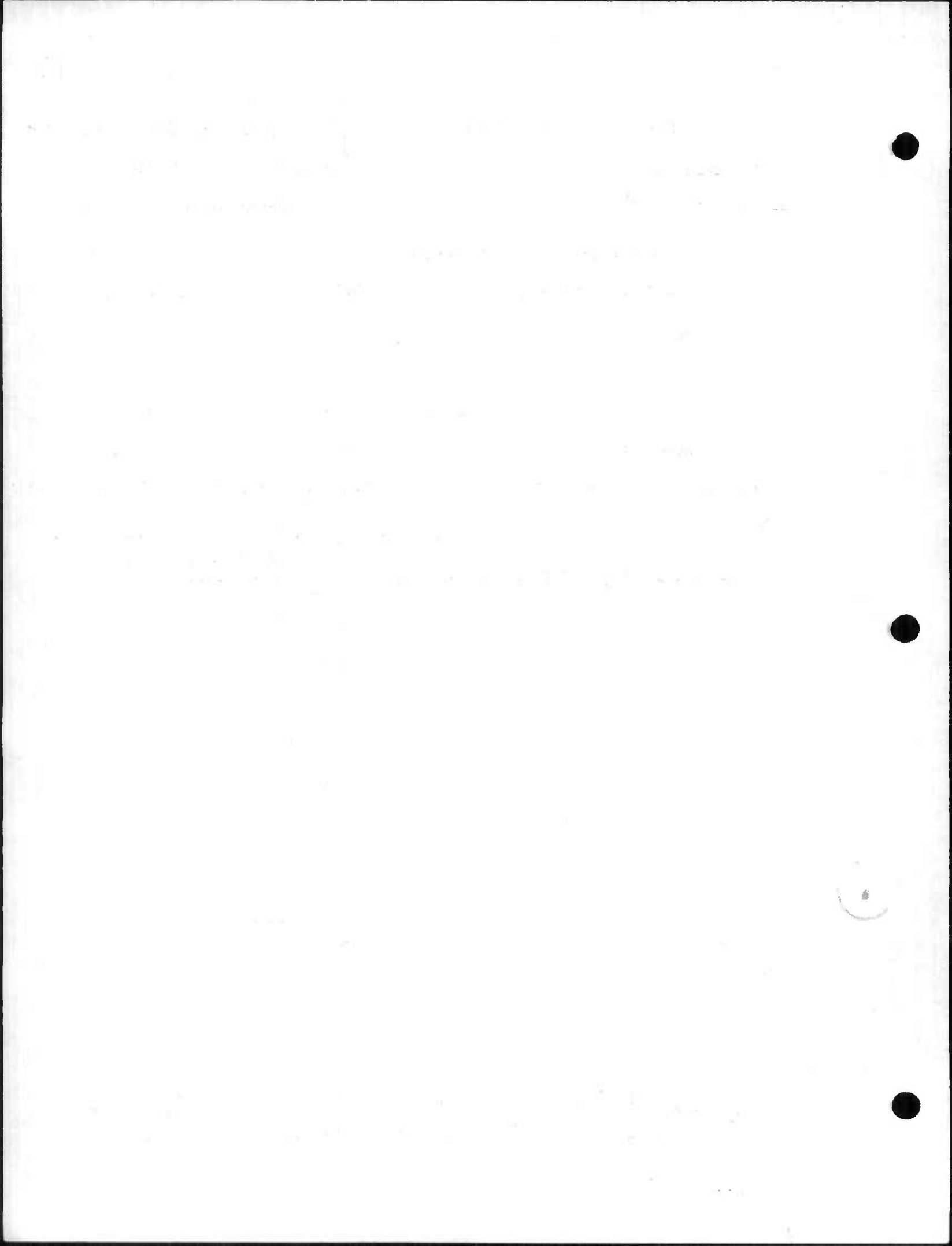
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRAYSON SYLVESTER BURRIER				2. Date of Death Month Day Year April 9, 1996		3. Time of Death 4:00 A.M.	
	4e. Facility Name (If not institution, give street and number) Citizens Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-01-1255		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) March 14, 1918	
	9. Birthplace (State or Foreign Country) Maryland		10a. State 21701		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1001 Carroll Parkway				10f. Zip Code 21701		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <u>W.W.II</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u>7</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teaching Professor		16b. Kind of Business/Industry College	
	17. Father's Name (First, Middle, Last) D. Grayson Burrier				18. Mother's Name (First, Middle, Maiden Surname) Mae Ramsburg			
	19a. Informant's Name/Relationship (Type, Print) Charlotte Eader Burrier (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Carroll Pkwy./Apt. 410/ Frederick, Maryland 21701			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State 4-12-96 Frederick, Maryland			
	21. Signature of Funeral Service Licensee <u>Raymond Peterson</u>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Parkinson's Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <u>1 week</u> <u>years</u>							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <u>Casper E. Cline, III</u>				29c. License number D 16428		29d. Date signed (Month, Day, Year) 4/10/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASPER E. CLINE, III, M.D./ 300 W. 9th St/ Frederick, Md. 21701							
	31. Date filed (Month, Day, Year) APR 17 1996				32. Registrar's Signature <u>John Davidson Randall</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13118

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Henry Bowlus</b>				2. Date of Death Month <b>April</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>0608</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington Co. Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>212-10-8218</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 8, 1912</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Middletown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>Old National Pike</b>			10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> Collage (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>truck driver</b>			16b. Kind of Business/Industry <b>concrete co.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John William Bowlus</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Haupt</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Margaret L. Bowlus (sister-in-law)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>501 W. Main St., Middletown, Md. 21769</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lutheran Cemetery</b>		Data <b>4/9</b>		20c. Location - City or Town, State <b>Middletown, Md.</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 week</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>right heart failure anterior ischemic cardiomyopathy</b> <b>diarrhea</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred							
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number <b>218019</b>		29d. Date signed (Month, Day, Year) <b>April 8, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Datta 334 mill Street Hagerstown MD</b>									
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the cause of death has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND Elkins CAIN Sr.

2. Date of Death

Month Day Year  
APRIL 19 1996

3. Time of Death

17:10

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

236-12-3531

6. Sex

M F

7. Age (In yrs, last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
6-19-1909

9. Birthplace (State or Foreign Country)

Elkins, WV

Usual Residence of Decedent

June

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5706 Mineral Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Brakeman

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

John William Cain

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Phillips

19a. Informant's Name/Relationship (Type, Print)

Ruth Custer Cain-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5706 Mineral Avenue, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Edge Hill Cemetery

Data

4-22-96 Charles Town, WV

21. Signature of Funeral Service Licensee

Douglas R. Snowden

22. Name and Address of Facility

Melvin I. Strider Co.  
P.O. Box 388, Charles Town, WV 25414

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UROSEPSIS

RENAL FAILURE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

F. Ansa, M.D.

29c. License number

P09514

29d. Date signed (Month, Day, Year)

APRIL 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS ANSA, MD

ST. AGNES HOSPITAL  
900 CATON AVENUE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

APR 23 1996

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13120

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Nellie Elizabeth Chaney				2. Date of Death Month Day Year April 20 1996		3. Time of Death 6:00AM		
	4a. Facility Name (If not Institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 216-05-7998	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 14, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedant								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1614 N. Market St.			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farm wife		16b. Kind of Business/Industry agriculture				
	17. Father's Name (First, Middle, Last) Ira Elbin Blentlinger				18. Mother's Name (First, Middle, Maiden Surname) Pearl May Dornburg				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sarah Keyser/ daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 N. Market St. Frederick, MD 21701					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery		Data 4/23/96		20c. Location - City or Town, State nr. Mt. Airy, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility D.D. Hartzler & Sons Libertytown, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. PULMOARY EDEMA Due to (or as a consequence of): b. ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 HOURS YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D43091		29d. Date signed (Month, Day, Year) 4-22-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAEED ZAIDI 801 TOLL HOUSE AVE, FREDERICK, MD									
31. Date filed (Month, Day, Year) APR 24 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-8.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13121

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Pedro L. Carreras</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1996</b>		3. TIME OF DEATH <b>10:08 p. M</b>	
4. SOCIAL SECURITY NUMBER <b>145-16-9195</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 15, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel Co.</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>		10d. INSIDE CITY LIMITS? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>14 Severndale Road</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Mexican</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b> <b>College (1-4 or 5+) 5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemical Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>City of Baltimore</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Pedro Juan Carreras</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Caroline Sues</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Loretta Carreras/Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Severndale Road-Severna Park, Maryland 21146</b>			
20a. METHOD OF DISPOSITION <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DATE</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald S. Wade, Dir.</b> <i>Ronald S. Wade</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street</b> <b>Baltimore, Maryland 21201-1559</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PERFORATED CARCINOMA RIGHT COLON</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. SEPTICEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. RETROPERITONEAL ABSCESS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>UNDERLYING MYOCARDIAL ISCHEMIA</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> <b>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>ASHOK RAJ MD, FACS</b>					
		29c. LICENSE NUMBER <b>D28724</b>		29d. DATE SIGNED (Month, Day, Year) <b>4.22.96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASHOK RAJ MD, 60 WEST ST # 210, ANNAPOLIS, MD 21401</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>		32. REGISTRAR'S SIGNATURE <i>J. Harrison-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edwin Cornett, JR.				2. Date of Death Month: April Day: 17 Year: 1996		3. Time of Death 1:05 PM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 219-44-4041		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth MARCH 31, 1944 <del>April 17, 1996</del>	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19614 Old Forge Road		10f. Zip Code 21742		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic/Self Employed		16b. Kind of Business/Industry Automotive		17. Father's Name (First, Middle, Last) James Edwin Cornett, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Josephine Baird		19a. Informant's Name/Relationship (Type, Print) Callista Barnhart FRIEND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19614 Old Forge Road Hagerstown, MD 21742		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		20c. Location - City or Town, State Hagerstown, MD		21. Signature of Funeral Service Licensee <i>Douglas A. Fiery</i>		22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., North Hagerstown, MD 21742	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael J. McCormack</i>	
State Registrar	29c. License number 041667		29d. Date signed (Month, Day, Year) 4.17.96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCormack 1799 Howell Road Hagerstown, MD 21740		31. Date filed (Month, Day, Year) APR 18 1996	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13123

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RALPH H. COBURN</b>				2. Date of Death Month <b>APRIL</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>8:08 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>401-18-6092</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 18, 1921</b>	9. Birthplace (State or Foreign Country) <b>KENTUCKY</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>30555 BENNETT ROAD</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>		16b. Kind of Business/Industry <b>POWER CO.</b>		
	17. Father's Name (First, Middle, Last) <b>FRANK COBURN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>OLLIE RICE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>RUTH COBURN</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30555 BENNETT ROAD, SALISBURY, MD. 21804</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GDNS.</b>		20c. Date <b>4/10</b>		20d. Location - City or Town, State <b>HEBRON, MD.</b>	
	21. Signature of Funeral Service Licensee <i>Gerald C. Bounds</i>			22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>MULTIPLE Cerebrovascular Accidents</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>not Recd 3/21/96</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent MYOCARDIAL INFARCTION</b> <b>PNEUMONIA AND SEPSIS</b>							
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael Atkins</i>		29c. License number <b>D-39813</b>		29d. Date signed (Month, Day, Year) <b>4/8/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>							
	31. Date filed (Month, Day, Year) <b>APR 09 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10



THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

TO THE  
HONORABLE  
MEMBERS OF THE  
NAVY

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98-13124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELOISE WOOLFORD CLARK</b>				2. Date of Death Month <b>April</b> Day <b>16</b> Year <b>1996</b>				3. Time of Death <b>1:50 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>470 West Dares Beach Road</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>				4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>219 12 3035</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Mar. 19, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Prince Frederick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>470 West Dares Beach Road</b>		10f. Zip Code <b>20678</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>physicians assistant</b>	
	16b. Kind of Business/Industry <b>health care</b>		17. Father's Name (First, Middle, Last) <b>Calvert Carroll Buckler, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Trott</b>		19a. Informant's Name/Relationship (Type, Print) <b>John L. Clark, Sr. / spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10 above</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>4-17-96</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Recent Myocardial Infarction</b> Due to (or as a consequence of): c. <b>Congestive Heart Failure</b> Due to (or as a consequence of): d. <b>Arteriosclerotic Cardiovascular Disease</b>		Approximate Interval Between Onset and Death <b>Minutes</b> <b>Weeks</b> <b>Weeks</b> <b>years</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
	29c. License number <b>D 17245</b>		29d. Date signed (Month, Day, Year) <b>April 17, 1996</b>		30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>Owings, Maryland 20736</b>		31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

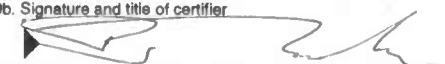
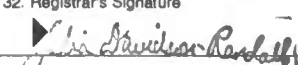
State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

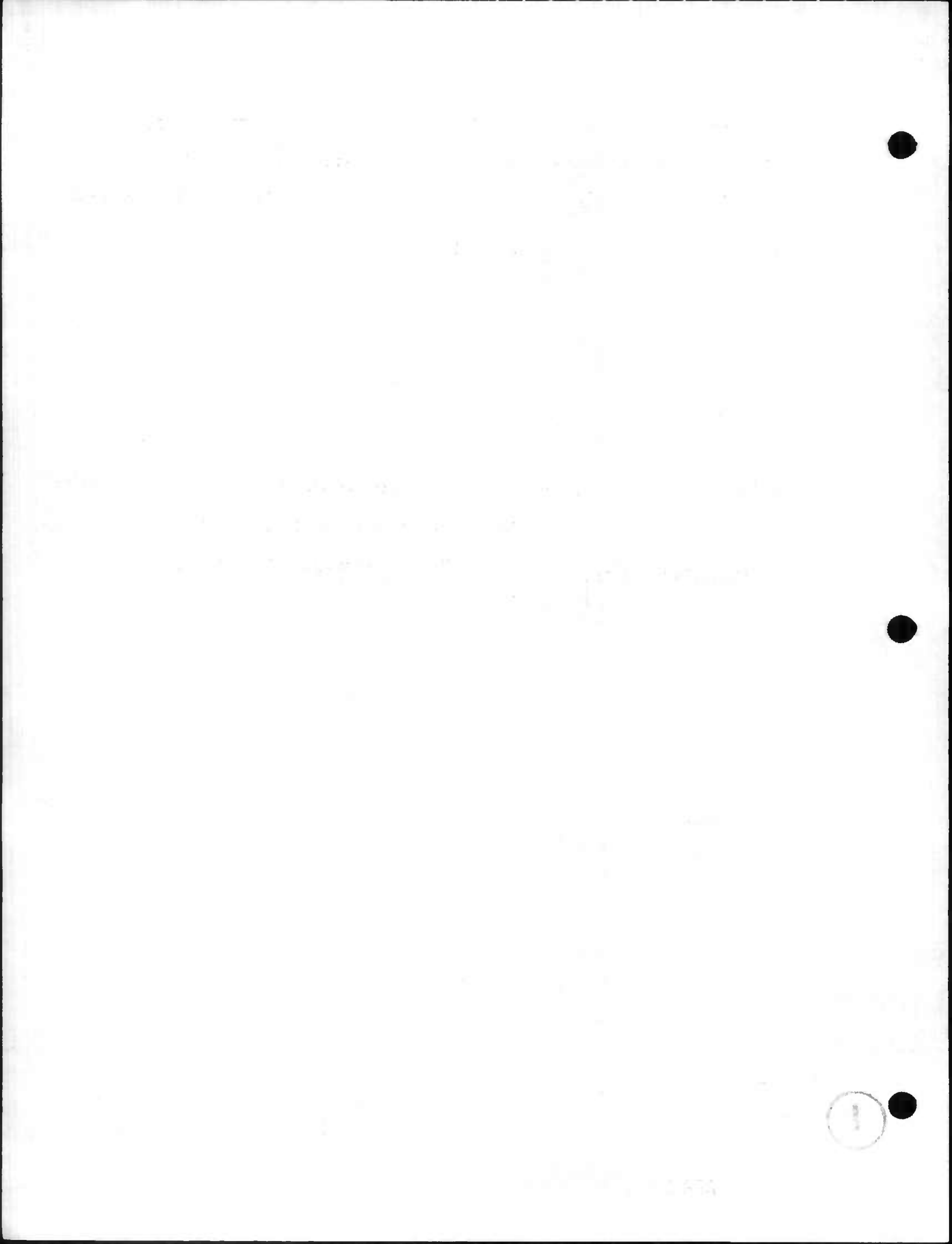
13125

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>EVELYN Catherine CUTSAIL</b>					2. Date of Death Month <b>APRIL</b> 17, Day <b>17</b> , Year <b>1996</b>		3. Time of Death <b>9:20 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>					4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
<b>Funeral Director</b>	5. Social Security Number <b>214-10-5807</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month <b>Feb.</b> 5, Day <b>5</b> , Year <b>1919</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
<b>To Be Completed by Funeral Director</b>	10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>1203 Pinewood Drive</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>	
	17. Father's Name (First, Middle, Last) <b>Harmon STALEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Esta STONE</b>				
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Janice L. Worsham, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>504 Fairview Avenue, Frederick, Maryland 21701</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery, April 20, 1996</b>			Date		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Richard E. Graf M00255</b>				22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Broncho pneumonia</b> Due to (or as a consequence of):</p> <p>b. <b>large pleural effusion</b> Due to (or as a consequence of):</p> <p>c. <b>metastatic cervical cancer</b> Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 25%;"> <p>Approximate Interval Between Onset and Death</p> <p>a. <b>2 d</b></p> <p>b. <b>2 weeks</b></p> <p>c. <b>4 mo</b></p> </div> </div>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D14626</b>		29d. Date signed (Month, Day, Year) <b>Apr 17, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Janice L. Worsham 504 Fairview Ave Frederick MD 21701</b>									
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13126

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH MAE CRAMER

2. Date of Death

April 15, 1996

3. Time of Death

12:05 AM

4a. Facility Name (If not institution, give street and number)

Frederick Healthcare Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-03-3029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 3, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Ford Road

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collage (1-4or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

laundry

16b. Kind of Business/Industry

Hood College

17. Father's Name (First, Middle, Last)

Foster Warrenfeltz

18. Mother's Name (First, Middle, Maiden Summa)

Gail Ramsburg

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Tyler/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

429 Center Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Hope Cemetery

Date

4/17/96

20c. Location - City or Town, State

Woodsboro, Maryland

21. Signature of Funeral Service Licensee

REP. B. Mackay

22. Name and Address of Facility

Stauffer Funeral Homes

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. BRAIN TUMOR

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

043091

29d. Date signed (Month, Day, Year)

4-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARAH ZANDI 801 TOLL HOUSE AVE, FREDERICK

State  
Registrar

31. Date filed (Month, Day, Year)

APR 17 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be attached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13127

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Leonard Cryer, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 20, 1996		3. TIME OF DEATH 7:45 P M	
4. SOCIAL SECURITY NUMBER 217-20-2152		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 31, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 40990 Cryer Court		9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Leonardtwn				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 40990 Cryer Court	
10f. ZIP CODE 20650				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Statistician		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Thomas Leonard Cryer, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Grace Stone			
19a. INFORMANT'S NAME (Type/Print) Mary L. Cryer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40990 Cryer Ct., Leonardtown, Maryland 20650			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Our Lady's Cemetery 4/24/96		20c. LOCATION — City or Town, State Leonardtwn, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.) IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Carcinoma of Left Lung</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Under the care of hospice</i>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James M. Moon, M.D.</i>			
29c. LICENSE NUMBER D09178				29d. DATE SIGNED (Month, Day, Year) 4/22/1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Youngsik Moon, M.D.				Hollywood, Maryland 20636			
31. DATE FILED (Month, Day, Year) APR 23 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13128

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JULIUS H. COOPER, JR.				2. Date of Death Month Day Year March 30 1996				3. Time of Death 1819	
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 222-03-9446		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Sept. 28, 1918		9. Birthplace (State or Foreign Country) DE.		10a. State Md.		10b. County Wicomico		10c. City, Town or Location Delmar	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 407 E. East St.				10f. Zip Code 21875				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant				16b. Kind of Business/Industry Self Employed Accounting	
	17. Father's Name (First, Middle, Last) Julius H. Cooper, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Marguerite Graham Cooper					
	19a. Informant's Name/Relationship (Type, Print) Carrie C. Cooper				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 E. East St. Delmar, Md. 21875					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cem. Park		Date 4-2-96		20c. Location - City or Town, State Delmar, De.			
	21. Signature of Funeral Service Licensee William M. Short				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sudden cardiac death Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Atherosclerosis Due to (or as a consequence of): d. Atherosclerosis				Approximate Interval Between Onset and Death 3-4					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier [Signature]				29c. License number D20441		
				29d. Date signed (Month, Day, Year) 3/30/96						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)										
31. Date filed (Month, Day, Year) APR 01 1996				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

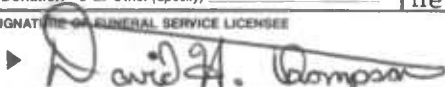
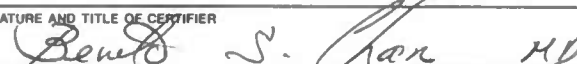

State Registrar



96 13129

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEFFERSON</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>2</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>2004</b> M					
4. SOCIAL SECURITY NUMBER <b>222-16-8154</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>September 18, 1928</b>				
8. BIRTHPLACE (State or Foreign Country) <b>Delaware</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1105 Hayes Ave.</b>				10f. ZIP CODE <b>21804</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Asbestos replacement-removal</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Commercial/industrial</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Erby P. Davis</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Warren</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Isabel Sally Davis</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1105 Hayes Ave., Salisbury, MD 21804</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Head of Christina</b>				DATE <b>4/5</b>		20c. LOCATION — City or Town, State <b>Newark, DE</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>Metastatic Lesion in Intra Peritoneal Cavity</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Chronic Renal Fail 20 Chron Stage 4</b> <b>- Pulmonary Atherosclerosis</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>						29c. LICENSE NUMBER <b>D-20050</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/3/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BENITO S. CHAN 541-D Riverside Dr. Salisbury MD 21801-</b>													
31. DATE FILED (Month, Day, Year) <b>APR 04 1996</b>				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13130

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>ANSON GIDION DEWITT</b>		2. Date of Death Month <b>4</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>12 32 P</b>
	4a. Facility Name (If not Institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>578-26-8486</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 2, 1923</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>925 Rolling Ridge Drive</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Repairman</b>		16b. Kind of Business/Industry <b>C&amp;P Telephone</b>
	17. Father's Name (First, Middle, Last) <b>Anson James DeWitt</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Blanche Wilson</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Inez R. DeWitt, Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>925 Rolling Ridge Drive, Westminster, MD 21157</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Branch Cemetery</b>		20c. Location - City or Town, State <b>Westminster, MD</b>
	21. Signature of Funeral Service Licensee <b>Katherine Pitts - Switzer</b>		22. Name and Address of Facility <b>Pitts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MASSIVE RIGHT FRONTO</b> Due to (or as a consequence of): <b>b. PARIETAL INTRACEREBRAL BLEED</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>36 HRS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier <b>Hafeez A Syed M.D.</b>		29c. License number <b>D25052</b>		29d. Date signed (Month, Day, Year) <b>4/17/96</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HAFAEZ A SYED 20 CROSSROADS DR. OWINGS MILLS 21117</b>				
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature <b>Jefia Decker Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13131

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Estelle P. Della</b>				2. Date of Death <b>March 9 1996</b>		3. Time of Death <b>8 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Fairfield Nursing Center</b>				4b. City, Town, or Location of Death <b>Crownsville</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>219-38-9317</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>03-20-1900</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
10a. State <b>MD.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crownsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>922 Johnson Grove Lane</b>				10f. Zip Code <b>21032</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeping</b>		16b. Kind of Business/Industry <b>Domestic</b>	
17. Father's Name (First, Middle, Last) <b>Thomas Pindell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Brewer</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mildred E. Henson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>922 Johnson Grove Lane Anne Arundel, MD. 21032</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Annapolis Mem. Gardens 4/12</b>		20c. Location - City or Town, State <b>Annapolis, MD.</b>		20d. Date <b>4/12</b>	
21. Signature of Funeral Service Licensee <b>Larry Reese</b>				22. Name and Address of Facility <b>821 West Street Reese &amp; Sons Mortuary Anna., MD. 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. chronic obstructive pulmonary disease</b> Due to (or as a consequence of): <b>b. coronary artery disease</b> Due to (or as a consequence of): <b>c. aortic</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>chronic</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Larry Reese, M.D.</b>				29c. License number <b>D-19528</b>		29d. Date signed (Month, Day, Year) <b>4/16/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ELINO M. GAYOSO 5411 Old Frederick Rd. Balto. MD- 21229</b>							
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>				32. Registrar's Signature <b>Judith Davidson-Randall</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Amended #1 4/16/96  
Agt

96 13132

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGUERITE JEANNETTE DART</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>12</b> YEAR <b>96</b>		3. TIME OF DEATH <b>3:15 PM</b>			
4. SOCIAL SECURITY NUMBER <b>214-14-5385</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b>		7. DATE OF BIRTH (Month, Day, Year) <b>March 23, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>				9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>				10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1016 Boom Court</b>				10f. ZIP CODE <b>21401</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>				16b. KIND OF BUSINESS/INDUSTRY <b>State Dept. of Education Div. of Vocational Rehab.</b>				17. FATHER'S NAME (First, Middle, Last) <b>William Diefel</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine Michaelson</b>				19a. INFORMANT'S NAME (Type/Print) <b>Andrea D. McLendon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1016 Boom Court, Annapolis, Maryland 21401</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory 4-15</b>				20c. LOCATION - City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, Md. 21401</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Small Cell Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>UNCERTAIN</b> <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>MD</b>				29c. LICENSE NUMBER <b>816354</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E.W. COLE III MD 900 BESTGATE RD SUITE 300 ANNAPOLIS MD 21401</b>				31. DATE FILED (Month, Day, Year) <b>APR 16 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 4. PER INFORMANT FILM G-735 5/23/96 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Patricia Ann Driscoll				2. DATE OF DEATH MONTH DAY YEAR April 10 1996		3. TIME OF DEATH 1854 M	
4. SOCIAL SECURITY NUMBER 23 218-32-1002		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 1 1928	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Arnold		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 566 Bay Dale Court				10f. ZIP CODE 21012		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Dennis V. Healy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Margaret Haggerty			
19a. INFORMANT'S NAME (Type/Print) Kathleen Sprouse				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1173 St. George Drive Annapolis, MD 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 4/15/96		20c. LOCATION — City or Town, State Cheltenham, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke Of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 18 mo							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John C. Murray, M.D.</i>		29c. LICENSE NUMBER D44465		29d. DATE SIGNED (Month, Day, Year) 4/11/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 900 Bestgate Road, Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) APR 16 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13134

Amended Item #6 per F.D. 4/30/96 C.C. P.L.C. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IDA I. DORSEY				2. Date of Death APRIL 19, 1996		3. Time of Death 1020 AM		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 212-62-3031		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 26, 1955	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1418 Taney Ave.				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) practical nurse		16b. Kind of Business/Industry home health care		
	17. Father's Name (First, Middle, Last) Charles W. Shern				18. Mother's Name (First, Middle, Maiden Surname) Marqueze Williams				
	19a. Informant's Name/Relationship (Type, Print) David F. Dorsey, Sr./ husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1418 Taney Ave., Apt. L303 Frederick, MD 21701				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain View Cemetery		Date 4/24/96		20c. Location - City or Town, State Union Bridge, MD		
	21. Signature of Funeral Service Licensee <i>Catherine O. Kartzler</i>				22. Name and Address of Facility D.D. Hartzler & Sons Libertytown, MD				
	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pulmonary thrombo-embolism</i> Due to (or as a consequence of):								
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Obesity Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obesity</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Andri...</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 20, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Andri...</i> 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) APR 24 1996		32. Registrar's Signature <i>John Andrew Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13135

Amended item #1 per F.D. 4/24/96 C.Co. P.L.C. Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis

4e. Facility Name (If not institution, give street and number)

103 S. Lightner St.

2. Date of Death

Month

Day

Year

4

14

96

3. Time of Death

Noon?

Funeral  
Director

5. Social Security Number

215-34-5017

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 13, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 S. Lightner St.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

cement co.

17. Father's Name (First, Middle, Last)

William David Duppins

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Nellie Davis

19a. Informant's Name/Relationship (Type, Print)

Linda Duppins/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13310 Hunter Hill, Apt. 1 Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oldfields Cemetery

Date

4/22/96

20c. Location - City or Town, State

nr. Libertytown, MD

21. Signature of Funeral Service Licensee

Catherine D. Hartzler

22. Name and Address of Facility

D.D. Hartzler & Sons  
Union Bridge, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Coronary heart disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Aug '90.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatic heart disease - years

Diabetes mellitus Sept '93.

Carcinoma Prostate June '95

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician 2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Caricabe MD

29c. License number

D 906

29d. Date signed (Month, Day, Year)

4/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. H. CARICABE MD, 104 N Main, Union Bridge MD 21791

31. Date filed (Month, Day, Year)

APR 24 1996

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
to the Health Officer or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13136

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willie Darns</b>			2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>			3. Time of Death <b>0100</b>				
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>				
Funeral Director	5. Social Security Number <b>266-48-5396</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-23, 1903</b>		9. Birthplace (State or Foreign Country) <b>Georgia</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Pocomoke City</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>32746 Rehobeth Rd. Pocomoke</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 Grade</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Farm Work</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Shump Darns</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mollie Whitley</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>James T. Darns</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32746 Rehobeth Rd. Pocomoke City, Md. 21851</b>						
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Cemetery</b>		Date <b>4/19/96</b>		20c. Location - City or Town, State <b>Pocomoke City, Md.</b>				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>46 Savage Funeral Home P.O. Box. New Church, Va. 23415</b>						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): <b>b. Generalized Atherosclerosis</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____									Approximate Interval Between Onset and Death <b>2 yrs</b> <b>5 yrs</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Prostatic Carcinoma</b> <b>Dementia</b> <b>Bilateral Basilar Pneumonitis</b>									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Gregorio M. Bellosso MD</i>		29c. License number <b>D29505</b>		29d. Date signed (Month, Day, Year) <b>4-12-96</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO M. BELLOSSO, M.D. 4421 BEECHWOOD PL., CRISFIELD, MD 21817</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>APR 17 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>								

Baltimore, Maryland 21215-0020

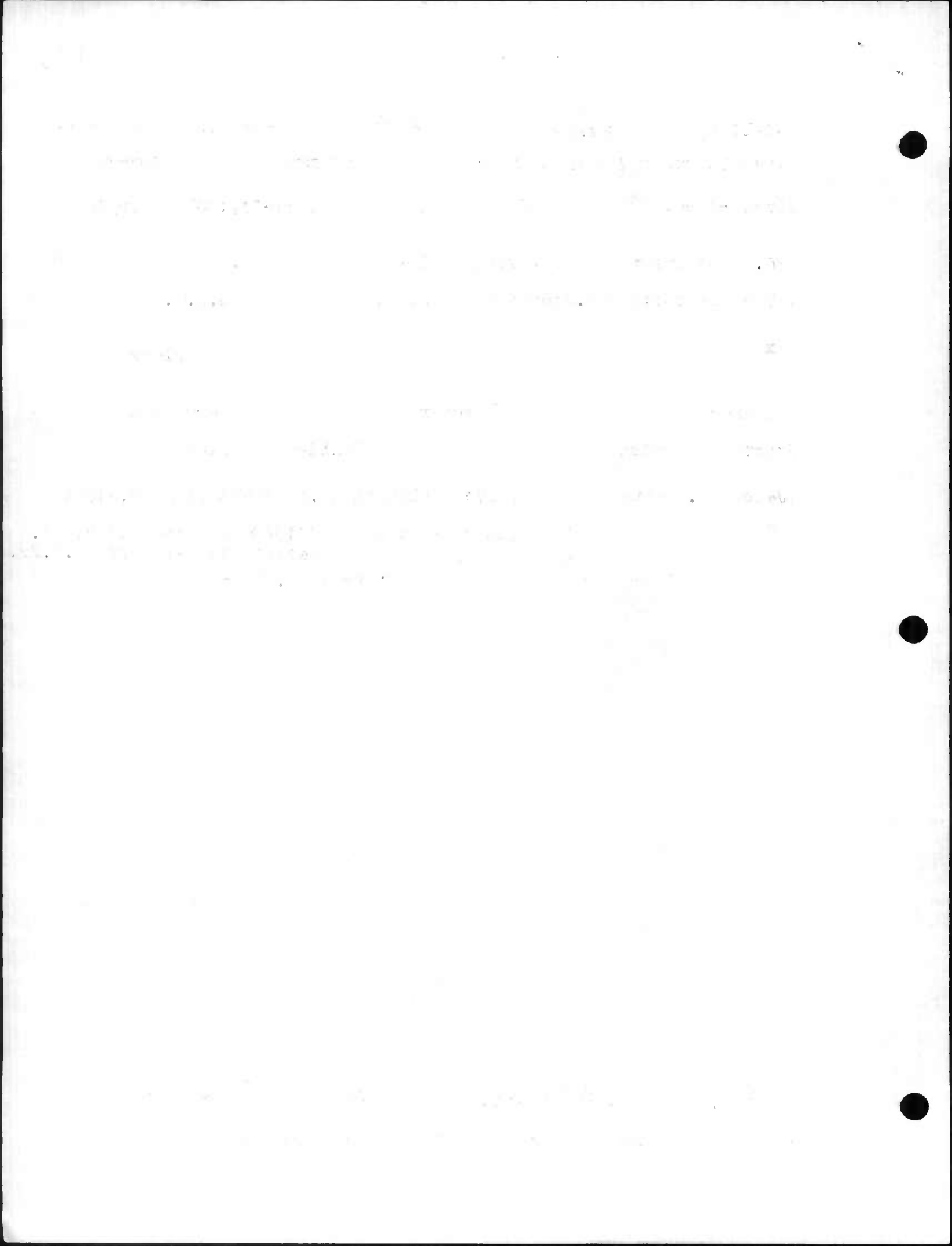
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

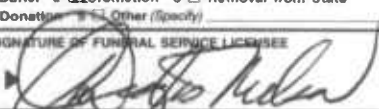
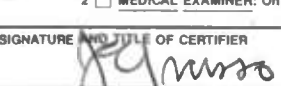

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 13137

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN EUNICE DURKEE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 1 1996</b>		3. TIME OF DEATH <b>1000</b> M	
4. SOCIAL SECURITY NUMBER <b>159-48-9917</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>9/4/1955</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>DELAWARE</b>				10b. COUNTY <b>SUSSEX</b>		10c. CITY, TOWN OR LOCATION <b>FRANKFORD</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>RD# 1 BOX SA 130 SHERWOOD ACRES</b>			
10f. ZIP CODE <b>19945</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CO-OWNER RESTAURANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOOD</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HOWARD NIXON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HONEY MYAMOTO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT DURKEE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RD# 1, BOX SA 130, SHERWOOD ACRES, FRANKFORD, DE 19945</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CAPE HENLOPEN CREMATORY 4/4/96</b>		20c. LOCATION — City or Town, State <b>FRANKFORD, DE 19945</b>		22. NAME AND ADDRESS OF FUNERAL HOME <b>MELSON FUNERAL SERVICES, LTD. FRANKFORD, DELAWARE 19945</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FUNERAL HOME <b>MELSON FUNERAL SERVICES, LTD. FRANKFORD, DELAWARE 19945</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic Non Small Cell Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval between Onset and Death <b>10 mo</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>D 20507</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/1/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph A. Grasso 145 E. CARROLL ST SALISBURY MD</b>							
31. DATE FILED <b>APR 03 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 13138

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Danny Gene Davey				2. DATE OF DEATH MONTH DAY YEAR April 12, 1996				3. TIME OF DEATH 1:15 P. M.	
4. SOCIAL SECURITY NUMBER 235-74-1869		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 30, 1946		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) P.O. Box 191				9b. CITY, TOWN OR LOCATION OF DEATH St. Leonard				9c. COUNTY OF DEATH Calvert	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION St. Leonard				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 191				10f. ZIP CODE 20685		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nuclear Medicine Technician				16b. KIND OF BUSINESS/INDUSTRY Medicine	
17. FATHER'S NAME (First, Middle, Last) George Thomas Davey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Virts					
19a. INFORMANT'S NAME (Type/Print) William D. Boyd II, M.D.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1753, Leonardtown, Maryland 20650					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) Charles Memorial 4/24/96				20c. LOCATION — City or Town, State Leonardtown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death Immed	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED VIA	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II, M.D.</i>				29c. LICENSE NUMBER D14285				29d. DATE SIGNED (Month, Day, Year) 4-16-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650									
31. DATE FILED (Month, Day, Year) APR 24 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13139

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Violet M. Discenza</b>				2. Date of Death Month Day Year <b>March 30 1996</b>				3. Time of Death <b>10:22 A.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center: Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury</b>				4c. County of Death <b>Wicomico</b>						
Funeral Director	5. Social Security Number <b>105-03-8100</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-02-15</b>		9. Birthplace (State or Foreign Country) <b>England</b>						
	Usual Residence of Decedent				10a. State <b>N.Y.</b>				10b. County <b>Ononadaga</b>		10c. City, Town or Location <b>Fayetteville</b>				
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>Little Fox Circle</b>				10f. Zip Code <b>13204</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>				16b. Kind of Business/Industry <b>Medical Records</b>						
	17. Father's Name (First, Middle, Last) <b>Thomas Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Wilson</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>Marilyn Bookmyer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26189 Pemberton Drive, Salisbury, Maryland 21801</b>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Minoa Methodist Cemetery</b>		Date <b>4/1/96</b>		20c. Location - City or Town, State <b>Minoa, N.Y.</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd.</b>				Salisbury, Md.						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARREST</b> Due to (or as a consequence of): <b>b. ASCVD</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>1 DAY</b> <b>10 YRS.</b>										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Robert Baker Allen M.D.</b>				29c. License number <b>D29168</b>		29d. Date signed (Month, Day, Year) <b>3/30/96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT B. ALLEN 560 RIVERSIDE DR., SALISBURY, MD.</b>				31. Date filed (Month, Day, Year) <b>APR 01 1996</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

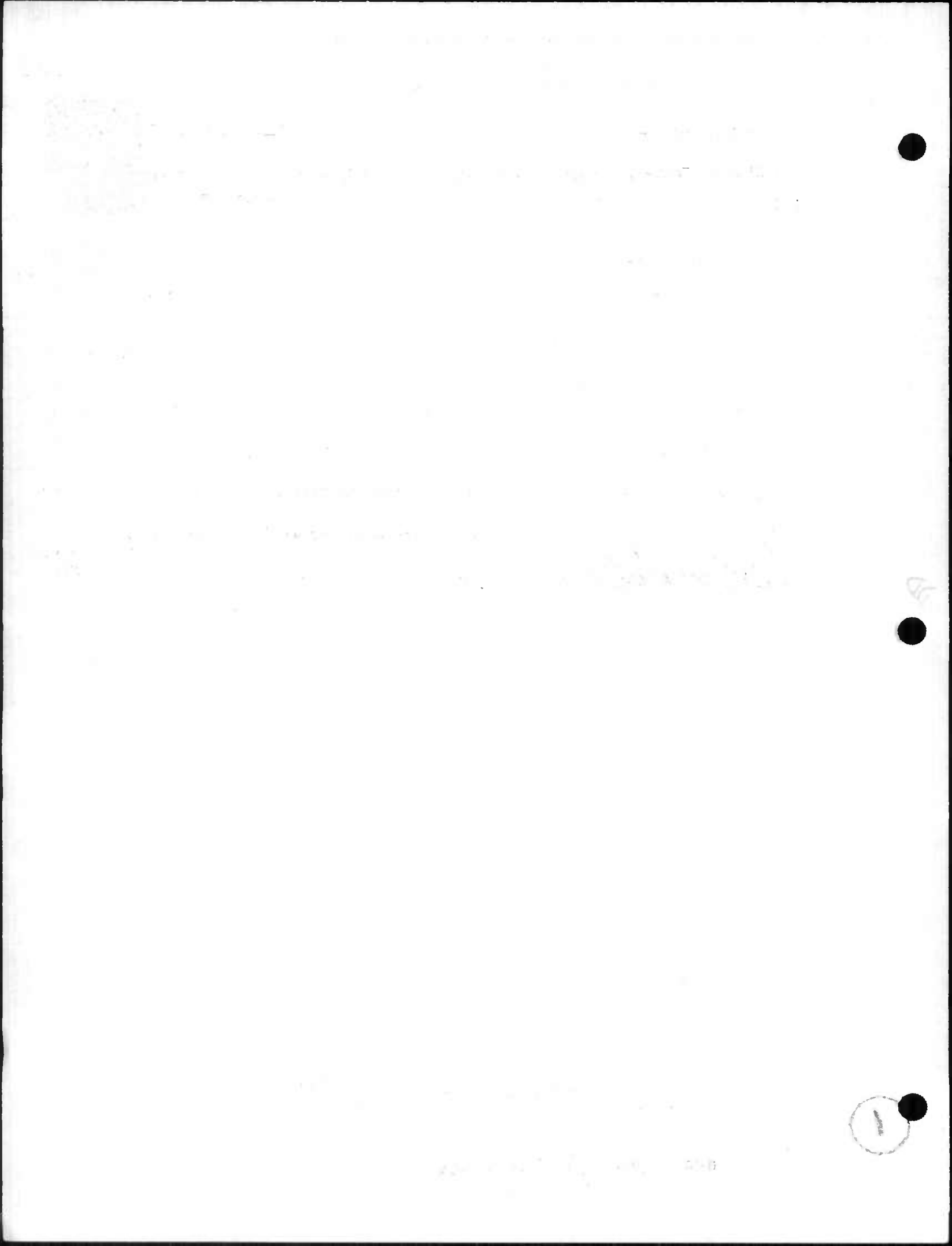
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13140

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER FRANCIS DUNNINGTON				2. Date of Death Month Day Year April 15 1996		3. Time of Death 4:00 am	
	4a. Facility Name (If not institution, give street and number) 163 Nutwell Road				4b. City, Town, or Location of Death Deale		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-01-9625		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) April 12, 1915	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Deale	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 163 Nutwell Road		10f. Zip Code 20751		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) fire fighter		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Walter W. Dunnington				18. Mother's Name (First, Middle, Maiden Surname) Maggie Hardesty			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Jackie Dunnington / spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) So. Memorial Gardens		20c. Location - City or Town, State 4/18/96 Dunkirk, MD		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Colon adenocarcinoma Due to (or as a consequence of): b. Left Upper Lobe Lung Mass - Probable Carcinoma 1 yr Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1-2 mos.
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia secondary colon Carcinoma Atherosclerotic Cardiovascular Disease Chronic Obstructive Lung Disease Anorexia - chronic						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29f. Signature and title of certifier Gerald P. Steiner MD	
To Be Completed by Physician/Medical Examiner	29g. License number D17245						29d. Date signed (Month, Day, Year) 4/16/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owings, Maryland 20736							
State Registrar	31. Date filed (Month, Day, Year) APR 19 1996				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

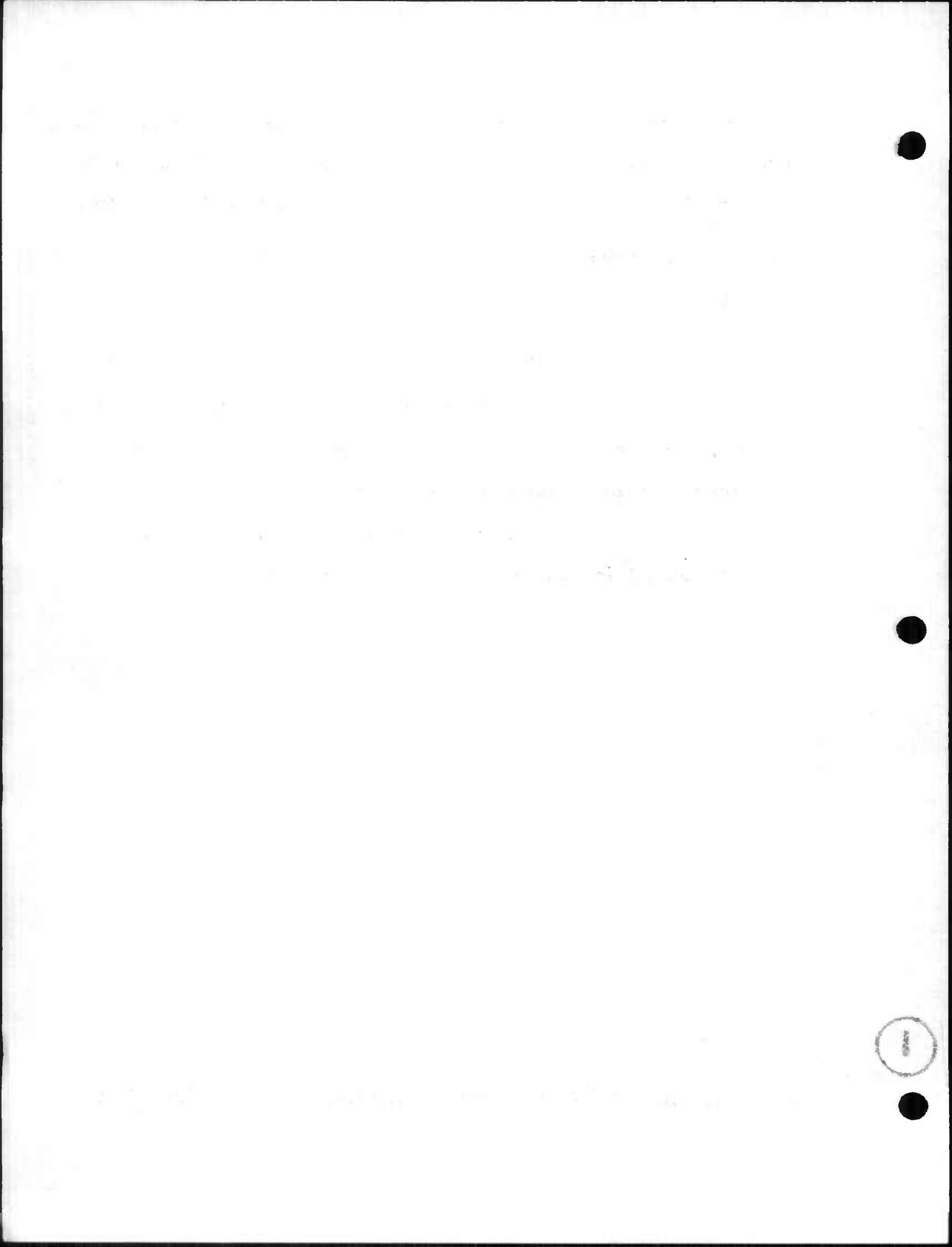
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

12+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13141

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH Mae DILLON				2. Date of Death Month Day Year April 16, 1996		3. Time of Death 1:40 AM		
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 283-10-7999		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 3, 1908		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent									
10a. State Maryland			10b. County Frederick			10c. City, Town or Location Frederick			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 8633 Indian Springs Road			10f. Zip Code 21702			
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own			17. Father's Name (First, Middle, Last) unknown			
18. Mother's Name (First, Middle, Maiden Surname) unknown			19a. Informant's Name/Relationship (Type, Print) James Dillon, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8633 Indian Springs Road Frederick, Maryland 21702			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bellevue Cemetery			20c. Location - City or Town, State Bellevue, Ohio			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death 5 yrs									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and Title of Certifier 			29c. License number D13971			29d. Date signed (Month, Day, Year) 4/16/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Kaufmann 300 West 9th Street Frederick, Maryland 21701									
31. Date filed (Month, Day, Year) APR 17 1996			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13142

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AMELIA

ANTONIOLLI

DEREGGI

2. Date of Death

Month Day Year

APRIL 14 1996

3. Time of Death

2145

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

221-22-3764

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 7, 1900

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Boysds

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

21000 Clarksburg Road

10f. Zip Code

20841

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home.

17. Father's Name (First, Middle, Last)

Natale Antonioli

18. Mother's Name (First, Middle, Maiden Surname)

Regina Poles

19a. Informant's Name/Relationship (Type, Print)

Marilyn DeReggi -Daughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15445 Barnesville Road, Boysds, Maryland 20841

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cathedral Cemetery

Date

4/18/96

20c. Location - City or Town, State

Wilmington, Delaware

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration

Due to (or as a consequence of):

b. Cerebral Arteriosclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

10 min

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James R Moore Jr MD

29c. License number

07231

29d. Date signed (Month, Day, Year)

April 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James R Moore Jr 207 Brookes Ave Gaithersburg MD 20877

31. Date filed (Month, Day, Year)

APR 19 1996

32. Registrar's Signature

James R Moore Jr

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13143

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Edwin Down				2. DATE OF DEATH MONTH DAY YEAR April 11, 1996				3. TIME OF DEATH 6:00 A M			
4. SOCIAL SECURITY NUMBER 510-20-3985		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1927		8. BIRTHPLACE (State or Foreign Country) Kansas			
9a. FACILITY NAME (If not institution, give street and number) 24704 Nickelby Drive				9b. CITY, TOWN OR LOCATION OF DEATH Damascus				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Damascus				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 24704 Nickelby Drive				10f. ZIP CODE 20872		10g. CITIZEN OF WHAT COUNTRY? U.S. A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Security			16b. KIND OF BUSINESS/INDUSTRY International Business Machines				
17. FATHER'S NAME (First, Middle, Last) Harry Edward Down				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Mary Cooper							
19a. INFORMANT'S NAME (Type/Print) Barbara A. Hood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29000 Ridge Road, Mount Airy, Maryland 21771							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Calvary Cemetery 4/16		20c. LOCATION — City or Town, State Topeka, Kansas							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John L. Williams</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>hepatocellular carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 6 mos.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>alcoholic cirrhosis</i> <i>diabetes</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. Melnick MD</i>				29c. LICENSE NUMBER D19294		29d. DATE SIGNED (Month, Day, Year) April 11, 1996					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN R. MELNICK 911 Russell Avenue, Gaithersburg, Maryland 20877											
31. DATE FILED (Month, Day, Year) APR 12 1996				32. REGISTRAR'S SIGNATURE <i>Theresa Mary Cooper</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The laws of Maryland require that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13144

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTHER RICHARD EVANS (Evans)</b>				2. Date of Death Month Day Year <b>April 17, 1996</b>		3. Time of Death <b>0030</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>222-07-5151</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07/13/17</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Snow Hill</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>307 B E. Market</b>		10f. Zip Code <b>21863</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Librarian</b>		16b. Kind of Business/Industry <b>Worcester Cty. Library</b>			
	17. Father's Name (First, Middle, Last) <b>Leland B. Richardson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Flossie Holland Richardson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>C. Barry Evans (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 St. David Dr., Mount Laurel, N. J. 08054</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Whatcoat Cemetery</b>		Date <b>4/20</b>		20c. Location - City or Town, State <b>Snow Hill, Md.</b>	
	21. Signature of Funeral Service Licensee <i>Patricia L. Dennis</i>				22. Name and Address of Facility <b>Dennis Funeral Home, P.O. Box 87 Snow Hill, Md. 21863</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>Chronic obstructive lung disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Piece of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>John A. Cockery</i>				29c. License number <b>025679</b>		29d. Date signed (Month, Day, Year) <b>4/17/96</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JA Cockery, 100 Power St., Salisbury, MD 21801</b>							
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>				32. Registrar's Signature <i>John A. Cockery</i>				

Baltimore, Maryland 21215-0020

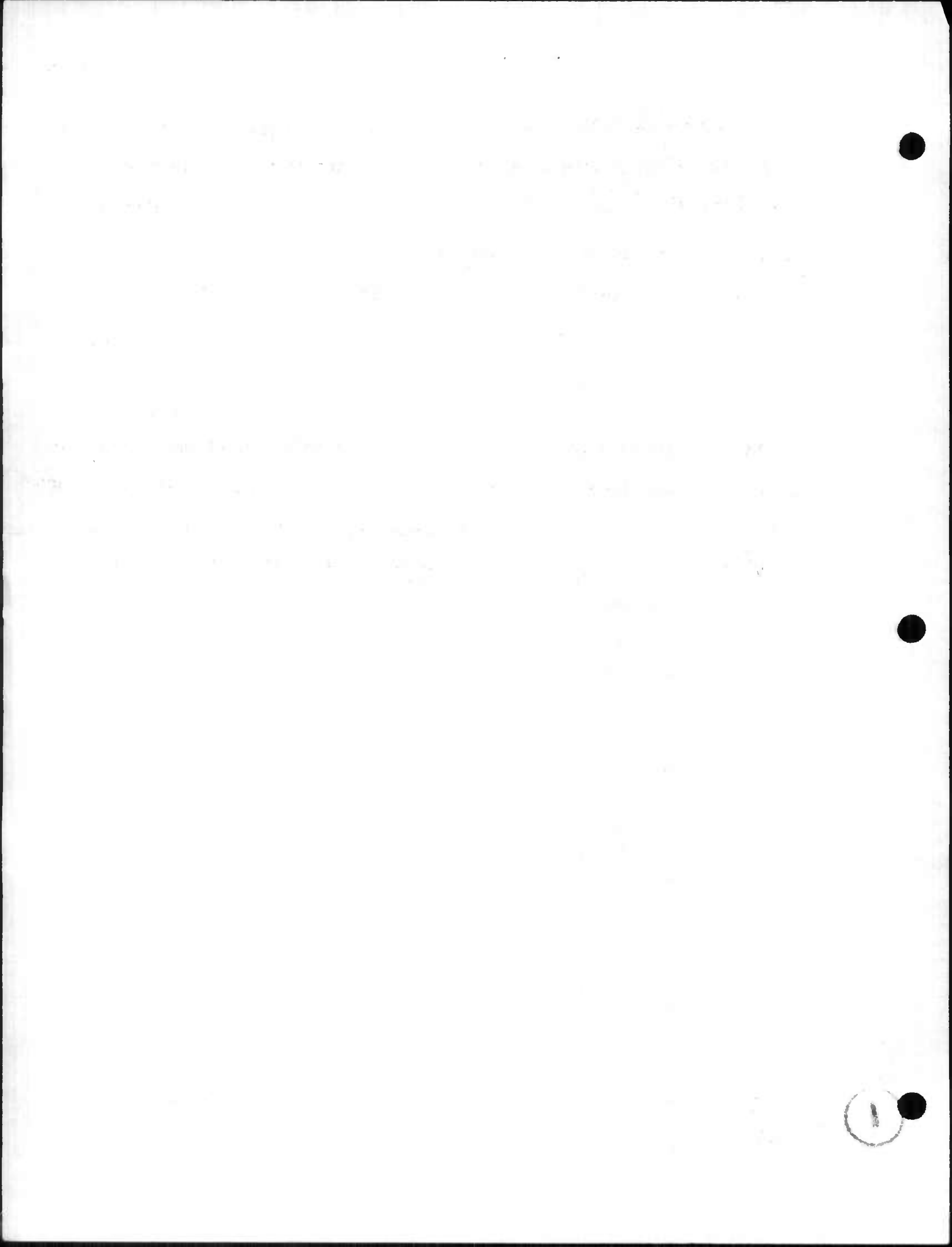
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13145

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES IRENE EVANS</b>				2. Date of Death Month <b>April</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>9:21 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>222-16-1684</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 2, 1930</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Riva</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>3192 Riva Road</b>		10f. Zip Code <b>21140</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced								
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:								
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Homemaker</b>								
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>								
16b. Kind of Business/Industry								
17. Father's Name (First, Middle, Last) <b>Raymond Wilson</b>								
18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Beatty</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Richard L. Evans</b>								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3192 Riva Road, Riva, Maryland 21140</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)								
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Lawn Cemetery</b>								
20c. Location - City or Town, State <b>4-16 Norfolk, Virginia</b>								
21. Signature of Funeral Service Licensee 								
22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, Maryland 21401</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>MYELOMONOCYTIC LEUKEMIA</b> Due to (or as a consequence of): <b>5Q- SYNDROME</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>4 months</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License number <b>D16364</b>								
29d. Date signed (Month, Day, Year) <b>4/12/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER R. GRAZE, MD 900 Bestgate Rd. #300, Annapolis, MD 21401</b>								
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a summary of the main findings and a discussion of the implications of the study. It includes a list of references and a list of figures and tables.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13146

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>CLARICE V. EDWARDS</b>				2. Date of Death Month Day Year <b>APRIL 14 1996</b>				3. Time of Death <b>2:00 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>MERIDIAN SPA-CREEK</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>				4c. County of Death <b>ANNE ARUNDEL</b>	
5. Social Security Number <b>219-26-9939</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 22 1938</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1030 EAST COLLEGE PARKWAY</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>US</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE AID</b>			16b. Kind of Business/Industry <b>SELF EMPLOYED</b>		
17. Father's Name (First, Middle, Last) <b>FRANK CROMWELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>VIRGINIA JOHNSON</b>					
19a. Informant's Name/Relationship (Type, Print) <b>DIANA FISHER (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1030 EAST COLLEGE PARKWAY ANNAPOLIS, MD. 21401</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS</b>		Date <b>4/19/96</b>		20c. Location - City or Town, State <b>ANNAPOLIS, MD.</b>	
21. Signature of Funeral Service Licensee <i>Larry D. Reese</i>				22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. End Stage Chronic Obstructive</b> Due to (or as a consequence of): <b>c. pulmonary disease</b> Due to (or as a consequence of): <b>d.</b>								Approximate interval Between Onset and Death <b>Days</b>  <b>Years -</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Peter Wehner MD</i>		29c. License number <b>D10653</b>		29d. Date signed (Month, Day, Year) <b>4-17-96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter VERKOUW MD 2003 Med. Plwy, Annapolis MD 21401</b>									
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>				32. Registrar's Signature <i>Julia Davidson-Randall</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Page 2  
The first part of the report is a summary of the work done during the last year. It is divided into two main sections: a general summary and a detailed account of the work done in each of the four departments.

The general summary is divided into three parts: a general statement of the work done, a statement of the results of the work, and a statement of the conclusions drawn from the work. The detailed account of the work done in each of the four departments is divided into four parts: a general statement of the work done, a statement of the results of the work, a statement of the conclusions drawn from the work, and a statement of the work done in each of the four departments.

The general statement of the work done is divided into two parts: a general statement of the work done and a statement of the results of the work. The statement of the results of the work is divided into two parts: a statement of the results of the work done in each of the four departments and a statement of the results of the work done in each of the four departments.

The statement of the results of the work done in each of the four departments is divided into four parts: a statement of the results of the work done in each of the four departments, a statement of the results of the work done in each of the four departments, a statement of the results of the work done in each of the four departments, and a statement of the results of the work done in each of the four departments.

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AMENDED # 1,5 AH  
4/23/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

13147

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hanson <del>Hansen</del> Moody <del>Elliott</del> <b>HANSON-Elliott</b>		2. Date of Death Month Day Year April 16 1996		3. Time of Death 7:30AM
	4a. Facility Name (If not institution, give street and number) 509 Sweet Gum Road		4b. City, Town, or Location of Death Riva		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 217-14-7488	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92	8. Date of Birth (Month, Day, Year) 10-24-1903	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Riva		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 509 Sweet Gum Road		10f. Zip Code 21140		10g. Citizen of What Country? United States
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent		18b. Kind of Business/Industry Insurance
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Wilson Elliott		18. Mother's Name (First, Middle, Maiden Surname) Lillie Sewell		
	19a. Informant's Name/Relationship (Type, Print) Olga Elliott/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Sweet Gum Road Riva, Maryland 21140		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens		20c. Location - City or Town, State Annapolis, Maryland
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 11 hours
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John D. Jackson		
	29c. License number D30718		29d. Date signed (Month, Day, Year) April 17, 1996		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John D. Jackson, M.D. 2003 Medical Parkway Suite 100 Annapolis, MD 21401		(410-573-1110)		
	31. Date filed (Month, Day, Year) APR 22 1996		32. Registrar's Signature Julia Davidson-Randall		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAZEL L. FLEET</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR. 10, 1996</b>		3. TIME OF DEATH <b>3:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>231-20-4032</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 10, 1898</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1000 EAST CHURCH STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. ZIP CODE <b>21804</b>	
10f. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BOOKKEEPER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HISTORICAL MANSION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HERMAN MILLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HAZEL F. BOWEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1000 EAST CHURCH STREET, SALISBURY, MD. 21804</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. FRANCIS CEMETERY 4/13</b>		20c. LOCATION — City or Town, State <b>KILMARNOK, VA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive heart failure</b>							
Sequitely ill conditions, if any, leading to IMMEDIATE CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary artery disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
28a. DATE OF INJURY (Month, Day, Year)							
28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>							
29c. LICENSE NUMBER <b>D25209</b>							
29d. DATE SIGNED (Month, Day, Year) <b>4/12/96</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN R. McLEAN 166 MILFORD ST SALISBURY, MD 21801</b>							
31. DATE FILED <b>APR 12 1996</b>							
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



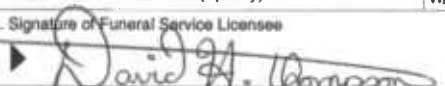

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13149

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John L. Farrell</b>				2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>0325</b>	
	4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>175-14-2292</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01-21-21</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>New York</b>		10b. County <b>Monroe</b>		10c. City, Town or Location <b>Rochester</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>202 Bay Village</b>				10f. Zip Code <b>14609</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Doctor</b>		16b. Kind of Business/Industry <b>Medicine</b>		
17. Father's Name (First, Middle, Last) <b>John Farrell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Moran</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carol Farrell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>202 Bay Village, Rochester, NY</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>White Haven Memorial Park</b>		Date <b>4/15/96</b>		20c. Location - City or Town, State <b>Perinton, NY</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>D.M.E.</b>		29c. License number <b>D03599</b>		29d. Date signed (Month, Day, Year) <b>4/11/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John T. Bulkeley, M.D. 108 Pine Bluff Road, Salisbury, MD</b>								
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 13150

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Fairfax Ford				2. DATE OF DEATH MONTH DAY YEAR April 22, 1996				3. TIME OF DEATH 7:46 P. M	
4. SOCIAL SECURITY NUMBER 217-14-2843		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	7. DATE OF BIRTH (Month, Day, Year) November 7, 1923		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Patuxent River Naval Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Patuxent River			9c. COUNTY OF DEATH St. Mary's		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Dameron			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER P.O. Box 163				10f. ZIP CODE 20628		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pipe Fitter			16b. KIND OF BUSINESS/INDUSTRY Civil Service		
17. FATHER'S NAME (First, Middle, Last) Joseph Fairfax Ford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Briscoe					
19a. INFORMANT'S NAME (Type/Print) Mary E. Ford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 163, Dameron, Maryland 20628					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter Claver 4/25/96		DATE 4/25/96		20c. LOCATION — City or Town, State St. Inigoes, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CHF						Approximate Interval Between Onset and Death 3 yrs	
		b. Due to (or as a consequence of): Cor a. dies						3 yrs	
		c. Due to (or as a consequence of): Aortic Valve disease						5 yrs	
		d. Due to (or as a consequence of): Cardiac arrest						1 day.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. K. Shah</i>				29c. LICENSE NUMBER D23634		29d. DATE SIGNED (Month, Day, Year) 4/23/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Vinod K. Shah, M.D. Route 5, Leonardtown, Maryland 20650									
31. DATE FILED (Month, Day, Year) APR 24 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 13151**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAROLD FOUT</b>				2. Date of Death Month Day Year <b>APRIL 15 1996</b>		3. Time of Death <b>2 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-10-5257</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 22, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Sykesville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>7309 Second Avenue</b>			10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>World War II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail Sales</b>			16b. Kind of Business/Industry <b>Grocery Store</b>		
	17. Father's Name (First, Middle, Last) <b>Edward F FOUT</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary GROVE</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Wayne D. Bruchey, P.R.</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1419 West 11th Street, Frederick, Maryland 21702</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>Apr 18, 1996</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Keeney &amp; Basford</i> MO0706			22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, Maryland 21701</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PNEUMONIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>5 DAYS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b> <b>HYPERTENSION</b> <b>COLON CANCER</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>K.S. RAO M.D.</b>		29c. License number <b>D 43462</b>		29d. Date signed (Month, Day, Year) <b>APRIL 15 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD</b>								
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

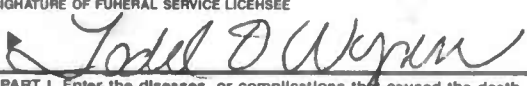


To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 13152

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ernest Otto FAHLFEDER Jr</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1996</b>		3. TIME OF DEATH <b>6:50 pm M</b>	
4. SOCIAL SECURITY NUMBER <b>220-38-4873</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 18, 1942</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3913 Sugarloaf Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Monrovia</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Monrovia</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3913 Sugarloaf Drive</b>	
10f. ZIP CODE <b>21770</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steamfitter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dry Cleaning/Laundry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Ernest O. Fahlfeder Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Minnick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ernest Todd Fahlfeder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10615 Watkins Road, Germantown Maryland. 20876</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc 4/15</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus Maryland 20872</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hodgkin's Disease</b> <b>Hypertension</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D35164</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Andrew Zarick, Jr., M.D., 130 Thomas Johnson Drive, #5, Frederick, MD 21702</b>							
31. DATE FILED (Month, Day, Year) <b>APR 15 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



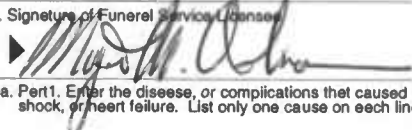


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13153

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN ANTHONY GOVAN</b>				2. Date of Death Month <b>APRIL</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>9:30 pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>Williamsport Nursing Home</b>				4b. City, Town, or Location of Death <b>Williamsport</b>		4c. County of Death <b>WASHINGTON</b>			
Funeral Director	5. Social Security Number <b>578-36-3913</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sep. 15, 1898</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Poolesville</b>	
To Be Completed by Funeral Director	10a. Street and Number <b>17104 Oxley Farm Rd.</b>				10f. Zip Code <b>20837</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Procurement Officer</b>		16b. Kind of Business/Industry <b>Government</b>			
	17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>					
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>Margy Gole</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17104 Oxley Farm Rd. Poolesville, MD 20837</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>4/22</b>		20c. Location - City or Town, State <b>Smithsburg, MD 21783</b>			
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>OSBORNE FUNERAL HOME</b> <b>P.O. Box # 348 Williamsport, MD 21795</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASPIRATION PNEUMONIA</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>10 DAYS</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADVANCED DEMENTIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D33700</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature 							

WRS 2000, 10/10/00



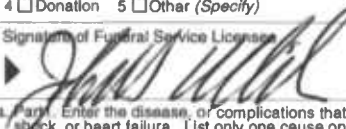
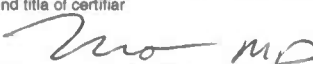
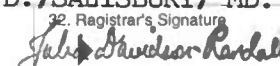
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13154

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA K. GREGORY			2. Date of Death Month Day Year APRIL 18 1996		3. Time of Death 8:30 AM	
	4a. Facility Name (If not Institution, give street and number) SALISBURY CENTER: GENESIS ELDERCARE			4b. City, Town, or Location of Death SALISBURY, MD.		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 214-30-7977		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 3-15-08
	10a. State MD.		10b. County WICOMICO		10c. City, Town or Location FRUITLAND		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number SAND CASTLE BLVD.			10f. Zip Code 21826		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		18b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) ALBERT J. SWEARINGEN			18. Mother's Name (First, Middle, Maiden Surname) SABRA CLARK			
	19a. Informant's Name/Relationship (Type, Print) LARRY M. GREGORY			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3644 MEADOWBRIDGE RD. SALISBURY, MD., 21801			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 4-21		20c. Location - City or Town, State BERLIN, MD.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD., 21811			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden CARDIAC Death Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
	23b. Approximate Interval Between Onset and Death Minutes						
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Active pneumonia - Recovering Acute Renal Failure, Dehydration SP, and Stenosis, Dehydration/CAD					
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
State Registrar	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 		29c. License number D-39813		29d. Date signed (Month, Day, Year) 4/18/96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., SALISBURY, MD. 21804						
	31. Date filed (Month, Day, Year) APR 22 1996						
32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 4a, 4c, PER STATE ANATOMY State of Maryland / Department of Health and Mental Hygiene 96 13155  
BOARD FILM G-735 5/6/96 t.t Certificate of Death

Reg. No.

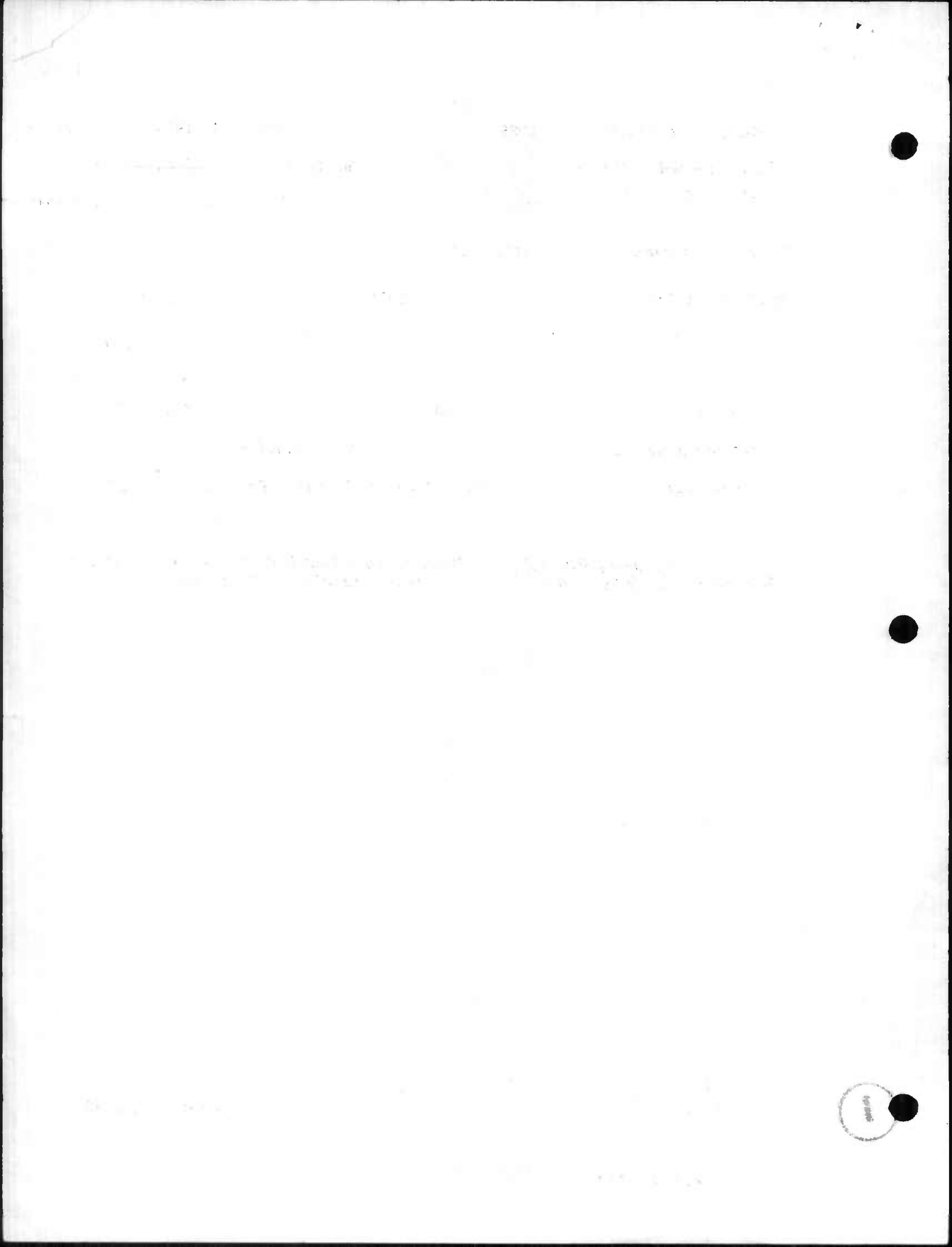
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH ALEXANDER GROSS</b>				2. Date of Death Month Day Year <b>APRIL 8, 1996</b>		3. Time of Death <b>09:40 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>233-16-6045</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 14, 1915</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>W. VA.</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Wiley Ford</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>Route 1-Box 35F</b>				10f. Zip Code <b>26767</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> Collega (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Railroad-CSX</b>		
17. Father's Name (First, Middle, Last) <b>Eugene Harrison Gross</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Maria Cunningham</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Luch Gross/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1-Box 35-F, Wiley Ford, W. VA. 26767</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Joseph B. Vansant</i>					22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Carcinomatosis</b>						Approximate Interval Between Onset and Death <b>4 months</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Causes of Colon</b>						<b>6 years</b>
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerosis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Wayne C. Spiggle</i>			29c. License number <b>D11443</b>		29d. Date signed (Month, Day, Year) <b>APRIL 8, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Wayne C. Spiggle - 912 Seton Dr - Cumberland, Md. 21502</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>			32. Registrar's Signature <i>John A. Randall</i>					

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



96 13156

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ADELAIDE W. GAGEBY</b>				2. DATE OF DEATH MONTH <b>JANUARY</b> DAY <b>16</b> YEAR <b>96</b>		3. TIME OF DEATH <b>3:30 P</b> M	
4. SOCIAL SECURITY NUMBER <b>214-12-1041</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 31, 1906</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Catonsville Community Convalescent Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>333 Harlem Lane</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th Grade</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Noah Webb</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Adina B. Mundie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Walt Latta</b>		(nephew)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>704 Trout Dale Terrace-Bel Air, Maryland 21014</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald S. Wade, Dir.</b>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypertensive Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Davidson</b>		29c. LICENSE NUMBER <b>D17537</b>		29d. DATE SIGNED (Month, Day, Year) <b>1-17-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DARSHAN S. SALWA MD 1600 W. MOUNT Royal Ave, Balto 21217</b>							
31. DATE FILED (Month, Day, Year) <b>JAN 06 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13157

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT LEROY GUNN

2. Date of Death

Month Day Year  
MARCH 31 1996

3. Time of Death

2:35 AM

4a. Facility Name (If not institution, give street and number)

407 -A KEENE AVENUE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-84-42-06

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

29

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1967

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Dames Quarter

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10786 Riley Roberts Rd.

10f. Zip Code

21820

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No  
Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Caretaker

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Robert G. Tate

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Gunn

19a. Informant's Name/Relationship (Type, Print)

Eugenia Gunn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10786 Riley Roberts Rd., Dames Quarter, MD 21820

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Paul's Cemetery

Date

4/6/96

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home  
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Contact Gun shot wound of head

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☒ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)

3-31-96

28b. Time of Injury

A 0130 M

28c. Injury at Work?

☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Residence

28d. Describe how Injury occurred

DECEDENT ACCIDENTALLY SHOT HIMSELF

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

4501 FINNEY AVE. BALTO.

29e. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 31, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 04 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
confirmed in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





A mended #15 art 4.22.96

96-1966-003

CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13158

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SALLY L. GILL</b>						2. Date of Death Month Day Year <b>APRIL 13, 1996</b>		3. Time of Death <b>2130 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>KNOLLWOOD NURSING HOME</b>						4b. City, Town, or Location of Death <b>MILLERSVILLE</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>214-62-0671</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>42</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 9 1952</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Mayo</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>1201 Dixona Drive</b>		10f. Zip Code <b>21106</b>		10g. Citizen of What Country? <b>United States</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mail Handler</b>		16b. Kind of Business/Industry <b>Post Office</b>							
17. Father's Name (First, Middle, Last) <b>Gail Rhudy</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary A. Booth</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey L. Gill/Husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1201 Dixona Drive Mayo, Maryland 21106</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		20c. Location - City or Town, State <b>4/17/96 Brentwood, Maryland</b>							
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Head injury, subdural hemorrhage, due to fall</b> Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic alcoholism with cirrhosis and coagulopathy</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>04-05-96</b>		28b. Time of Injury <b>unk</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject fell</b>			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>201 DIXONA DR. Edgewater, Anne Arundel MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Donald G. Wright MD</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 14, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald G. Wright MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>APR 22 1996</b>		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13159

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAZEL ELIZABETH GOLDSTEIN</b>				2. Date of Death Month Day Year <b>APRIL 20 1996</b>				3. Time of Death <b>0522</b>	
	4a. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>				4c. County of Death <b>CALVERT</b>	
Funeral Director	5. Social Security Number <b>579 28 1503</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 27 1917</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Prince Frederick</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1110 Oakland Hall</b>				10f. Zip Code <b>20678</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>3</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attorney</b>			16b. Kind of Business/Industry <b>Legal</b>		
	17. Father's Name (First, Middle, Last) <b>Jesse Clingan Horton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Mae Gregg</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Louis L. Goldstein / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 1110 Oakland Hall Prince Frederick Maryland 20678</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wesley Cemetery April 22, 1996</b>			20c. Location - City or Town, State <b>Prince Frederick Cal. Maryland</b>		
	21. Signature of Funeral Service Licensee <b>B. Rausch</b>				22. Name and Address of Facility <b>Rausch Funeral Home P.A. 4405 Brookes Island Road Port Republic Maryland 20676</b>					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>SEPSIS</b> Due to (or as a consequence of): b. <b>PERFORATED SIGMOID COLON</b> Due to (or as a consequence of): c. <b>DIVERTICULAR DISEASE</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>3-4 DAYS</b> <b>10-12 DAYS</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STERIOD DEPENDENT CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND RHEUMATOID ARTHRITIS</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Dr. H. Westel</b>				29c. License number <b>D26358</b>		29d. Date signed (Month, Day, Year) <b>APRIL 20, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAN H. WESTEL MD - PRINCE FREDERICK MD - 20678</b>									
	31. Date filed (Month, Day, Year) <b>APR 23 1996</b>				32. Registrar's Signature <b>John Davidson-Randall</b>					
	State Registrar									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13160

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY FRANKLIN HOLMES

2. Date of Death

Month

Day

Year

April

17

1996

3. Time of Death

5:10 pm

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

214-18-7694

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT. 10, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18218 LAPPANS ROAD

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941 &amp; 1942

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HEAD CUSTODIAN

16b. Kind of Business/Industry

PUBLIC SCHOOL

17. Father's Name (First, Middle, Last)

JOHN FRANKLIN HOLMES

18. Mother's Name (First, Middle, Maiden Surname)

BETSY ELIZABETH DOUGHERTY

19a. Informant's Name/Relationship (Type, Print)

JEANNETTE C. HOLMES/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18218 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MIN. VIEW CEMETERY

Date

4/20/96

20c. Location - City or Town, State

SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

ONE WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

10 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INFECTED DECUBITUS ULCERS

SEVERE ARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D44996

29d. Date signed (Month, Day, Year)

APRIL 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAFAR MALIK 20311 LAPPANS RD BOONSBORO MD 21713

State  
Registrar

31. Date filed (Month, Day, Year)

APR 19 1996

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13161

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Stephen Herring</b>				2. Date of Death Month <b>April</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>1:05 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>17002 Hillside Court</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>345 58 2856</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-26-41</b>	
	9. Birthplace (State or Foreign Country) <b>Louisiana</b>		10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>17002 Hillside Court</b>		10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Self-employed</b>				
17. Father's Name (First, Middle, Last) <b>Cecil G. Herring</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta Theresa Derouler</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gary Grimes Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17002 Hillside Ct. Hagerstown, Md. 21740</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		20c. Location - City or Town, State <b>4/19/96 Hagerstown, Maryland</b>				
21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>		22. Name and Address of Facility <b>Gerald N. Minnich 305 N. Potomac St. Hagerstown, Maryland</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>Respiratory Failure</b> Due to (or as a consequence of): <b>HIV/AIDS Encephalitis</b> Due to (or as a consequence of): <b>HIV infection</b> Due to (or as a consequence of): <b>HIV infection</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death <b>Minutes</b> <b>Weeks</b> <b>years</b></p> </div> </div>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Mark W. Galt</i>		29c. License number <b>D 31880</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARK W. GALT, JR MD 1110 Medical Campus Rd. HAGERSTOWN, MD</b>								
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature <i>John A. ...</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13162

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAZEL LOUISE HAYWARD				2. Date of Death Month Day Year April 21 1996		3. Time of Death 7:48 AM												
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester												
Funeral Director	5. Social Security Number 217-14-8590		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 20 1906												
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Maryland																
To Be Completed by Funeral Director	10a. State Maryland	10b. County Dorchester		10c. City, Town or Location Cambridge			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
	10e. Street and Number 709 Locust St.			10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) instructional assistant		16b. Kind of Business/Industry public school system														
	17. Father's Name (First, Middle, Last) Charles Lee Larrimore				18. Mother's Name (First, Middle, Maiden Surname) Alice Henry Watts														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Armond Hayward II - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Locust St. Cambridge, MD 21613														
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 4/23		20c. Location - City or Town, State Salisbury Maryland												
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge, MD 21613														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. septic shock</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. urinary sepsis</td> <td>4 hours</td> </tr> <tr> <td>c. urine tract infection</td> <td>1 day</td> </tr> <tr> <td>d.</td> <td>unknown</td> </tr> <tr> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. septic shock	Approximate Interval Between Onset and Death	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. urinary sepsis	4 hours	c. urine tract infection	1 day	d.	unknown	
Immediate Cause (Final disease or condition resulting in death)	a. septic shock	Approximate Interval Between Onset and Death																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. urinary sepsis	4 hours																	
	c. urine tract infection	1 day																	
	d.	unknown																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus (ketoacidosis) Alzheimer's Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-28209		29d. Date signed (Month, Day, Year) April 21, 1996													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmund J. MacLaughlin 4 Aurora St. Cambridge, Md 21613																			
31. Date filed (Month, Day, Year) APR 22 1996		32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

John Glynn Holton

## Certificate of Death

Reg. No.

96 13163

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>JOHN G. HOLTON</b>				2. Date of Death Month <b>4</b> Day <b>21</b> Year <b>96</b>		3. Time of Death <b>2:15 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
5. Social Security Number <b>327-30-6667</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 22, 1918</b>	
9. Birthplace (State or Foreign Country) <b>England</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>101 High Street</b>		10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>US</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Episcopal Minister</b>		16b. Kind of Business/Industry <b>Ministry</b>			
17. Father's Name (First, Middle, Last) <b>William James Holton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Davis</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joan Holton</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 High Street Cambridge, Maryland 21613</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>4/22</b>		20c. Location - City or Town, State <b>Salisbury, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613</b>			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)			
a. <b>SEPSIS</b> Due to (or as a consequence of):		<b>3 days.</b>	
b. <b>BOWEL OBSTRUCTION</b> Due to (or as a consequence of):		<b>3 days.</b>	
c. <b>CIRRHOSIS - END STAGE</b> Due to (or as a consequence of):		<b>4/25</b>	
d. <b>DIABETES</b> Due to (or as a consequence of):		<b>4/25</b>	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HBP, Renal FAILURE</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
		29c. License number <b>D22773</b>	
		29d. Date signed (Month, Day, Year) <b>4/21/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HUBERT L. FERY MD 503 BYRN ST. CAMBRIDGE MD 21613</b>			
31. Date filed (Month, Day, Year) <b>APR 22 1996</b>		32. Registrar's Signature 	

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



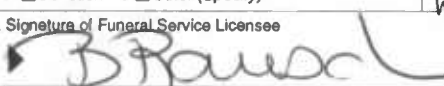
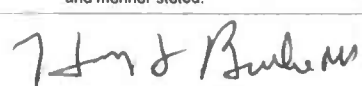
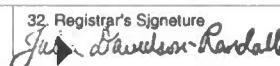
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13164

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET EUNICE HARDESTY</b>				2. Date of Death Month <b>April</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>6:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CHARLES COUNTY NURSING-REHABILITATION CENTER</b>				4b. City, Town, or Location of Death <b>LA PLATA MD.</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>212 74 4761</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 27 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Charles</b> 10c. City, Town or Location <b>LaPlata</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) _____		16. Kind of Business/Industry <b>homemaker</b>		
17. Father's Name (First, Middle, Last) <b>Williams Myers Barnes</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Monnett</b>		19a. Informant's Name/Relationship (Type, Print) <b>Any B. Clark</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 509 LaPlata Md. 20646</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Waters Memorial Cemetery</b>		20c. Location - City or Town, State <b>St. Leonard Maryland</b>		20d. Date <b>April 22, 1996</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home</b> <b>4405 Broomes Is. Rd. Port Republic Maryland 20676</b>		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Cardiac arrest</b> Due to (or as a consequence of): <b>c. </b> Due to (or as a consequence of): <b>d. </b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cause of Breast</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>001009</b>		29d. Date signed (Month, Day, Year) <b>4-20-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)								
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13165

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Dean Hill Jr.				2. Date of Death Month: April Day: 10 Year: 1996		3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 213-04-3206		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 13 Yrs.		8. Date of Birth (Month, Day, Year) May 30, 1982	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 467 West South Street		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry Middle School				
17. Father's Name (First, Middle, Last) Michael Dean Hill, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Deborah Lynn Snoots				
19a. Informant's Name/Relationship (Type, Print) Michael D. Hill, Sr., Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 West South Street, Frederick, MD 21701				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, April 13, 1996		20c. Location - City or Town, State Frederick, Maryland				
21. Signature of Funeral Service Licensee Allan H Ruby MO0703		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>profound thrombocytopenia</u> Due to (or as a consequence of): b. <u>Burkett's lymphoma</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number D14676		29d. Date signed (Month, Day, Year) APR 10, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O G Roberts 501 W. Streets & Frederick MD								
31. Date filed (Month, Day, Year) APR 12 1996		32. Registrar's Signature D. Anderson-Randall						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The undersigned certifies that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13166

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Heald</b>				2. Date of Death Month <b>April</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>10:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>1800 Bollinger Road</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>212-05-4296</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 19, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1800 Bollinger Road</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>worker</b>		16b. Kind of Business/Industry <b>BG &amp; E Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Roland P. Peloquin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Esther V. Heald</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ann Heald, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1800 Bollinger Road, Westminster, MD 21157</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		Date <b>04/25/96</b>		20c. Location - City or Town, State <b>Pikesville, MD</b>	
	21. Signature of Funeral Service Licensee <b>Katherine Palto - Switzer</b>				22. Name and Address of Facility <b>Pitts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Renal Failure 2° obstructive</b> Due to (or as a consequence of): <b>c. myocardial A&amp;HD</b> Due to (or as a consequence of): <b>d. coronary art disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <b>Thompson MD</b>		29c. License number <b>038915</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRE 101 295 8th Ave Rd Westminster, MD 21157</b>							
	31. Date filed (Month, Day, Year) <b>APR 24 1996</b>		32. Registrar's Signature <b>John W. ...</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper  
deals with the general theory  
of the subject and the  
second part with the  
application of the theory to  
the case of the present problem.

The first part of the paper  
deals with the general theory  
of the subject and the  
second part with the  
application of the theory to  
the case of the present problem.

The first part of the paper  
deals with the general theory  
of the subject and the  
second part with the  
application of the theory to  
the case of the present problem.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13167

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BESSIE FLORENCE HITCHENS</b>				2. Date of Death Month <b>April</b> Day <b>1</b> Year <b>1996</b>				3. Time of Death <b>12:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury, Md.</b>				4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>220-26-2212</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>October 25, 1910</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Eden</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>14573 Foltz Dr.</b>		10f. Zip Code <b>21822</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aid</b>	
	16b. Kind of Business/Industry <b>Medical</b>		17. Father's Name (First, Middle, Last) <b>John Maurice</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Gootee</b>		19a. Informant's Name/Relationship (Type, Print) <b>Loretta Knight</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>131 Liberty Way, Fruitland, MD 21826</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>4/1/96</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Carcinoma of Cervix &amp; Metas. 1995</b> <b>b. Pulmonary embolism - w/infarct 1995</b> <b>c. Aneurysm 1995</b> <b>d. Renal Insufficiency 1995</b>		Approximate Interval Between Onset and Death <b>1995</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>(2) 7x w/ig</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>029349</b>		29d. Date signed (Month, Day, Year) <b>4/1/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1104 HEALTHWAY DR., SALISBURY, MD 21801</b>		31. Date filed (Month, Day, Year) <b>APR 02 1996</b>		32. Registrar's Signature 		State Registrar			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13168

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>John Edward HANES</b>				2. Date of Death Month <b>April</b> Day <b>15</b> Year <b>1996</b>				3. Time of Death <b>12:58 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>John Hopkins Bay View Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>220-16-3162</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Sept. 4, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Brunswick</b>	
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Brunswick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>605 Sixth Avenue</b>		10f. Zip Code <b>21716</b>
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Crane Operator</b>		16b. Kind of Business/Industry <b>RailRoad</b>		17. Father's Name (First, Middle, Last) <b>Richard HANES</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Mary LOWERY</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Frances L. Suprik, Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7843 Scholar Road, Baltimore, Maryland 21222</b>
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium or other place) <b>Saint Pauls Cemetery</b>		Date <b>April 18, 1996</b>		20c. Location - City or Town, State <b>Point of Rocks, Maryland</b>		21. Signature of Funeral Service Licensee <b>Richard E. Hill M00255</b>		22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701</b>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary embolism</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Severe coronary atherosclerosis</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>minutes</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe coronary atherosclerosis</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Gary S. Hill, M.D.</b>										
29c. License number <b>D09277</b>										
29d. Date signed (Month, Day, Year) <b>4/16/96</b>										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Gary S. Hill, M.D., JHBM, Baltimore, MD 21224</b>										
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>										
32. Registrar's Signature <b>Division Randall</b>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 13169

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betty Lou Hughes</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>16</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>7:17 P</b>	
4. SOCIAL SECURITY NUMBER <b>166-34-3054</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 6, 1941</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>				10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Monrovia</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>3904 Sugarloaf Drive</b>	
10f. ZIP CODE <b>21770</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sanford Neale</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nell Moser</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Elbert Hughes Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3904 Sugarloaf Drive, Monrovia Maryland 21770</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Locust Grove Cemetery 4/20/1996</b>				20c. LOCATION — City or Town, State <b>Mt. Airy Maryland.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Todd D. Wynn</i>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth P.A. Funeral Home 26401 Ridge Road Damascus, Maryland. 20872</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Death</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Sudden Death</b> b. <b>Sudden Death</b> c. <b>Sudden Death</b> d. <b>Sudden Death</b>								Approximate Interval Between Onset and Death <b>2 1/2 weeks</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Obesity</b> <b>Diabetes</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur G. Manalo</i>				29c. LICENSE NUMBER <b>D-18191</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 17, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arthur G. Manalo, M.D. 11801 Fingerboard Rd., Monrovia, Md. 21770</b>									
31. DATE FILED (Month, Day, Year) <b>APR 19 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Radcliff</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #1 &amp; ITEM # 18

State of Maryland / Department of Health and Mental Hygiene

WCHD 04/08/96 PJS

## Certificate of Death

Reg. No.

96 13170

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY LOUISE

HUTCHISON

~~HUTCHINSON~~

2. Date of Death

Month  
03Day  
31Year  
96

3. Time of Death

1120

4a. Facility Name (If not institution, give street and number)

300 POPLAR STREET

4b. City, Town, or Location of Death

FRUITLAND

4c. County of Death

WICOMICO

5. Social Security Number

221-09-8819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

11-08-14

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Wicomico10c. City, Town or Location  
Fruitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Poplar St., Apt. 302

10f. Zip Code

21826

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Woodrow Adams

18. Mother's Name (First, Middle, Maiden Surname)

EDNA PEARL TOWNSEND  
Cinderella (unknown)

19a. Informant's Name/Relationship (Type, Print)

Deborah Ann Paquette

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34844 Poplar Neck Rd., Pittsville, MD 21850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

4/4/96

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D03599

29d. Date signed (Month, Day, Year)

04-01-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

APR 02 1996

32. Registrar's Signature

John Bulkeley-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13171

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL LAWRENCE HOLT</b>				2. Date of Death Month Day Year <b>April 20 1996</b>		3. Time of Death <b>2:13 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Hospital</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>219-16-1014</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sep 6, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Loveville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>Rt. 2 Box 153</b>				10f. Zip Code <b>20656</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equipment Operator</b>		16b. Kind of Business/Industry <b>U.S. Government</b>		
17. Father's Name (First, Middle, Last) <b>William Matthew Holt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Marie Brown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Thyris M. Miles</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2 Box 99, Morganza, MD 20660</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Queen of Peace Cemetery</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>Helen, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Michael R. Gardiner</i>				22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac arrest</b> Due to (or as a consequence of): <b>b. Diabetes mellitus</b> Due to (or as a consequence of): <b>c. Hypertensive arteriosclerotic cardiovascular disease</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death  Years  Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Youngsik Moon</i>		29c. License number <b>D09178</b>		29d. Date signed (Month, Day, Year) <b>4/22/1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. YOUNGSIK MOON HOLLYWOOD, MD 20636</b>								
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature <i>Jill Anderson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13172

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mark Joseph INFUSINO</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>9</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>12:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>153-48-6399</b>		5. SEX <b>XX</b> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>40</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 7, 1956</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>5703 Trailview Court, Apt. A 32</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>			9c. COUNTY OF DEATH <b>Frederick</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>5703 Trail View Court, Apt. A 32</b>				10f. ZIP CODE <b>21703</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <b>5+</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Board of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Anthony INFUSINO</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Connie MILONE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Frank A. Infusino, Father</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 Southwood Drive, Old Bridge, New Jersey 08857</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc. place) <b>Cloverleaf Cemetery, April 13, 1996</b>			20c. LOCATION — City or Town, State <b>Woodbridge, New Jersey</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard E. Graf</b> <b>MO0255</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Complication of Acquired Immune Deficiency Syndrome</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>Deficiency Syndrome</b>  c.  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								Approximate Interval Between Onset and Death <b>2 Yrs.</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael C. Postale MD</b>		29c. LICENSE NUMBER <b>D-21119</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 10, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael C. Postale MD 2112 E St Suite 603 WASH DC 20037</b>									
31. DATE FILED (Month, Day, Year) <b>APR 11 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate was executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #7-8 on  
4.22.96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13173

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alfred E. Judy</b>			2. Date of Death Month <b>Apr</b> Day <b>19</b> Year <b>96</b>		3. Time of Death <b>0946</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Gen Hosp Annapolis</b>			4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>AA</b>	
Funeral Director	5. Social Security Number <b>217-26-2563</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Dec 31 1929</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	10a. State <b>MD</b>			10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Greenbelt</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>22 Ridge Road</b>			10f. Zip Code <b>20770</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			18b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>David P. Judy</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Orpha Furlow</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Josephine Judy/Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 Ridge Road Greenbelt, Maryland 20770</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Memorial Church Cemetery</b>		20c. Location - City or Town, State <b>Everett, Pennsylvania</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Cardiac Failure</b> Due to (or as a consequence of):  b. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>UNK</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>William P. Jones Deputy</b>				
			29c. License number <b>D 06054</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>			31. Date of Death (Month, Day, Year) <b>APR 19 1996</b>				
32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 13174

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nellie May Jones				2. DATE OF DEATH MONTH DAY YEAR April 18 1996		3. TIME OF DEATH 3:45P M	
4. SOCIAL SECURITY NUMBER 029-22-2475		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 16 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Anne Arundel			
9a. FACILITY NAME (If not institution, give street and number) 775 Polling House Road				9b. CITY, TOWN OR LOCATION OF DEATH Harwood		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Harwood		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 775 Polling House Road				10f. ZIP CODE 20776		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Principal & Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) William T. Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Wier			
19a. INFORMANT'S NAME (Type/Print) Elizabeth J. Wayson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Polling House Road Harwood, Maryland 20776			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion U.M. Church Cemetery 4/21/96		20c. LOCATION — City or Town, State Harwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke Of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Chronic Bronchitis c. Fistula in ano d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P.H.D., D.O.				29c. LICENSE NUMBER H36078		29d. DATE SIGNED (Month, Day, Year) 4/19/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) STEVEN FULLER 900 Bethesda Rd., Suite 300, Annapolis, MD 21403							
31. DATE FILED (Month, Day, Year) APR 22 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13175

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>COURTNEY M. JAMES</b>				2. Date of Death Month Day Year <b>March 28, 1996</b>		3. Time of Death <b>9: 15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>6413 Davis Rd.</b>				4b. City, Town, or Location of Death <b>Mt. Airy,</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>217-13-4281</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>10</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 16, 1986</b>	
	9. Birthplace (State or Foreign Country) <b>Kentucky</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6413 Davis Rd.</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>student</b>		16b. Kind of Business/Industry <b>-</b>			
	17. Father's Name (First, Middle, Last) <b>Frank James, Jr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Fox</b>		19. Informant's Name/Relationship (Type, Print) <b>Dorothy Fox Lyons (mother)</b>			
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven memorial</b>		20c. Date <b>4-1-96</b>		20d. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>		22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>1621 Opossumtown pike/ Frederick, Md. 21702</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ASPIRATION PNEUMONIA</b> Due to (or as a consequence of): <b>b. SPASTIC QUADRAPLEGIA</b> Due to (or as a consequence of): <b>c. 10 year</b>			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To the Hospital or Attending Physician: The law requires that a death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28a. Date of Injury (Month, Day Year) <b>APR 1 1996</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>20528 BOLLAND FARM Rd #204 GERMANTOWN, MD 20876.</b>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>20528 BOLLAND FARM Rd #204 GERMANTOWN, MD 20876.</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
State Registrar	29b. Signature and title of certifier <i>Gary Brecher MD</i>		29c. License number <b>D03634</b>		29d. Date signed (Month, Day, Year) <b>APR 1 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GARY BRECHER MD 20528 BOLLAND FARM Rd #204 GERMANTOWN, MD 20876.</b>		31. Date filed (Month, Day, Year) <b>APR 04 1996</b>		32. Registrar's Signature <i>Richard Randall</i>			

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various expeditions and the collections made. The second part of the report is devoted to the study of the different groups of animals and plants which have been discovered. The third part of the report contains the conclusions of the various expeditions and the results of the various studies. The fourth part of the report is devoted to the study of the different groups of animals and plants which have been discovered. The fifth part of the report contains the conclusions of the various expeditions and the results of the various studies.

2. The second part of the report is devoted to the study of the different groups of animals and plants which have been discovered. The third part of the report contains the conclusions of the various expeditions and the results of the various studies.

3. The third part of the report contains the conclusions of the various expeditions and the results of the various studies. The fourth part of the report is devoted to the study of the different groups of animals and plants which have been discovered.

4. The fourth part of the report is devoted to the study of the different groups of animals and plants which have been discovered. The fifth part of the report contains the conclusions of the various expeditions and the results of the various studies.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Joseph Reed Jameson

2. Date of Death Month Day Year April 20, 1996

3. Time of Death 1020

4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital

4b. City, Town, or Location of Death Prince Frederick

4c. County of Death Calvert

5. Social Security Number 579-16-0549

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 75 Yrs.

8. Date of Birth (Month, Day, Year) Nov. 2, 1920

9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland

10b. County St. Mary's

10c. City, Town or Location Leonardtown

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number Cedar Lane Apt. #2108

10f. Zip Code 20650

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 2 Married

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pasteurizer

16b. Kind of Business/Industry Diary Company

17. Father's Name (First, Middle, Last) John Walter Jameson

18. Mother's Name (First, Middle, Maiden Surname) Florence Rena Crismond

19a. Informant's Name/Relationship (Type, Print) Josephine L. Jameson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cedar Lane Apts. #2108, Leonardtown, MD 20650

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery

20c. Location - City or Town, State Cheltenham, MD

21. Signature of Funeral Service Licensee Michael L. Gardiner

22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. respiratory failure Due to (or as a consequence of): 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. renal failure Due to (or as a consequence of): 2 days

c. Acute MI Due to (or as a consequence of): 2 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA. Status post sigmoid resection

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D47598

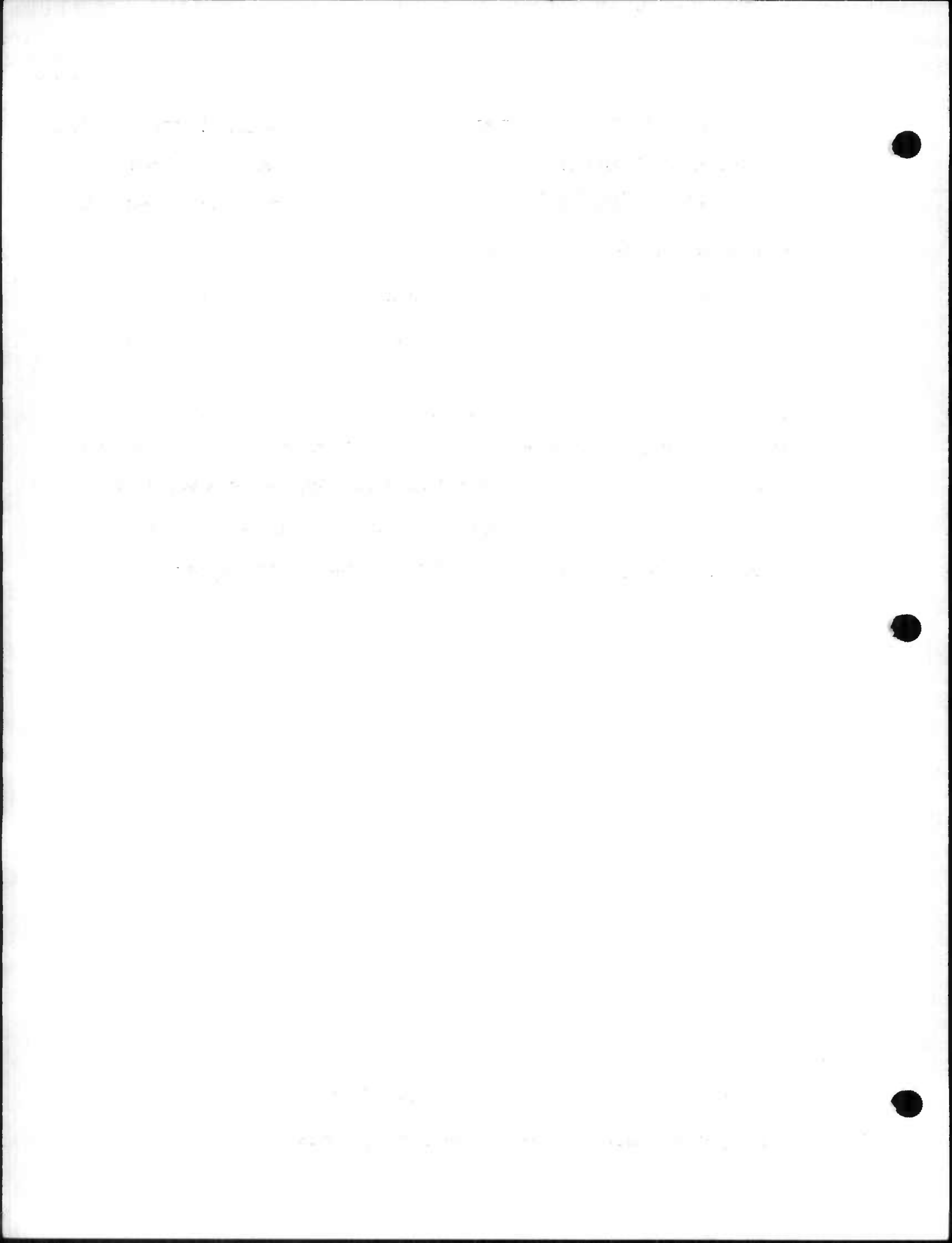
29d. Date signed (Month, Day, Year) 9/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry H. Molouki, M.D., Prince Frederick, Md. 20678

31. Date filed (Month, Day, Year) APR 23 1996

32. Registrar's Signature

State Registrar



96-2115-013

CIP ITEMS: 23 PART I, II, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene  
PER NEO FILM G-735 5/9/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

96 13177

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH WALTON KLINGER</b>			2. Date of Death Month <b>APRIL</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>7:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CARROLL COUNTY GENERAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>157-18-2080</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 21, 1926</b>
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Westminster</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>304 Klinger Drive</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>L. Arthur Walton</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Ackerman</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dr. R.P. Klinger, husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>304 Klinger Drive, Westminster, MD 21157</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremations Inc.</b>		Date <b>04/19/96</b>	20c. Location - City or Town, State <b>Hampstead, MD</b>	
	21. Signature of Funeral Service Licensee <b>Katherine Pites - Switzer</b>			22. Name and Address of Facility <b>Pitts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SALICYLATE INTOXICATION Dua to (or as a consequence of): b.  Dua to (or as a consequence of): c.  Dua to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONTRIBUTORY METASTATIC CARCINOMA OF BREAST</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>4/17/96</b>		28b. Time of Injury <b>3:26 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			28d. Describe how injury occurred <b>SUBJECT INGESTED DRUG</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>304 KLINGER DRIVE WESTMINSTER, MD. 21157</b>		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <b>Monty P. Shul</b>			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 18, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marysue A. Korze 1111 Penn Street, Baltimore, Maryland 21201</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature <b>John H. ...</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13178

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Darnley Koivisto</b>				2. Date of Death Month <b>4</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>3<sup>00</sup> AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>220-44-1736</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 16, 1914</b>	9. Birthplace (State or Foreign Country) <b>W. VA</b>
	Usual Residence of Decedent							
10a. State <b>Ohio</b>		10b. County <b>Belmont</b>		10c. City, Town or Location <b>Bellaire</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4665 1/2 Jefferson Street</b>				10f. Zip Code <b>43906</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Fed. Government</b>		
17. Father's Name (First, Middle, Last) <b>John Darnley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Hupengartner</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dennis D. Koivisto (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5404 Sea Breeze Court, Cambridge, MD. 21613</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cambridge Crematory</b>		Date <b>4-18</b>		20c. Location - City or Town, State <b>Cambridge, MD.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Colon Cancer</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 weeks</b> <b>1 Month</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>William Bair MD</i>		29c. License number <b>043238</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Bair 19 Franklin St. Cambridge, MD 21613</b>								
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>				32. Registrar's Signature <i>John Anderson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13179

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth Hadder Knox</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10 1996</b>		3. TIME OF DEATH <b>8:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-05-9289</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>July 13, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Wicomico Nursing</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Parsonsburg</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8121 Esham Rd.</b>	
10f. ZIP CODE <b>21849</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas E. Hadder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Richardson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Aline Kenney</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8121 Esham Rd., Parsonsburg, MD 21849</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Pittsville Cemetery 4/12</b>		20c. LOCATION — City or Town, State <b>Pittsville, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David H. Thompson</i>				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Terminal Pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Alzheimer Disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Approximate Interval Between Onset and Death</b> <b>3 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HSVD. Severe CAD.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.G. Arthes, MD, 1622 A Ocean Pines, Berlin, Md. 21811</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876  
BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13180

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hubert Glenn Kemp</b>				2. Date of Death Month <b>April</b> Day <b>20</b> Year <b>1996</b>				3. Time of Death <b>0730</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>				4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>234-52-8368</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 22, 1934</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>	
To Be Completed by Funeral Director	10a. Street and Number <b>5485 Huntingtown Road</b>				10f. Zip Code <b>20639</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1957-59</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>equipment service specialist</b>		16b. Kind of Business/Industry <b>automotive</b>			
	17. Father's Name (First, Middle, Last) <b>Clarence Harrison Kemp</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Lucille Helmick</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Carolyn A. Kemp/spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10 above</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Miranda Cemetery</b>		Data <b>4/24/96</b>		20c. Location - City or Town, State <b>Huntingtown, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Merkel Cell Carcinoma with Diffuse</b> Due to (or as a consequence of): <b>Lymphatic Spread/Liver Metastases</b> <b>b. Renal Failure</b> Due to (or as a consequence of): <b>Hepatic (Liver) Failure</b> Due to (or as a consequence of): <b>c. Hepatic (Liver) Failure</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>6-7 months</b> <b>Days</b> <b>Weeks</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Hyperglycemia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D17245</b>		
29d. Date signed (Month, Day, Year) <b>April 21, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gerald P. Sterner, M.D., Owings, Md. 20736</b>						
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Philip Ambler LONG				2. DATE OF DEATH MONTH DAY YEAR April 18, 1996		3. TIME OF DEATH 3:15p m	
4. SOCIAL SECURITY NUMBER 169-07-4918		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 28 1901	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Ravenwood Lutheran Village		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1183 Luther Drive	
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY SelfEmployed	
17. FATHER'S NAME (First, Middle, Last) George Edward Long				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Ann Paskin			
19a. INFORMANT'S NAME (Type/Print) Carolyn L. <del>Garrigan</del> CORRIGAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3767 Red Oak Court New Orleans, La. 70131-8427			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Homewood Cemetery 5-24-96		20c. LOCATION — City or Town, State Pittsburgh, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Minnich				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute heart failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Chan				29c. LICENSE NUMBER D36655		29d. DATE SIGNED (Month, Day, Year) 4/19/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1185 MI AETNA RD Hagerstown MD 21740							
31. DATE FILED (Month, Day, Year) 4-19-96 APR 22 1996				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





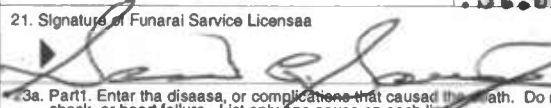
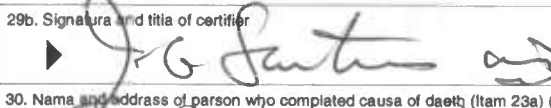
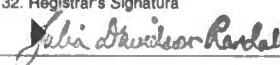
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13182

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred Elizabeth Cropper Lankford</b>						2. Date of Death Month Day Year <b>April 13, 1996</b>		3. Time of Death <b>4:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1970 Coloma Rd.</b>						4b. City, Town, or Location of Death <b>Pocomoke City</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>218-20-3502</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6/4/1921</b>		9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke City</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1970 Coloma Rd.</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>7 Grad</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Chicken Plant</b>					
	17. Father's Name (First, Middle, Last) <b>Henry Cropper</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Madgie Beckett</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Inez L. Parks</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1970 Coloma Rd Pocomoke City, Md. 21851</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. James Cemetery</b>		Date <b>4/17/96</b>		20c. Location - City or Town, State <b>Pocomoke City, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>P.O. Box 46 Savage Funeral Home New Church, Va. 23415</b>					
	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARCINOMA OF LUNG</b> Due to (or as a consequence of): <b>W/ GENERALIZED METASTASIS</b>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>002556</b>		29d. Date signed (Month, Day, Year) <b>4/16/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. G. Santanis, M.D. 100 8th Street, Pocomoke City, Md 21851</b>										
31. Date filed (Month, Day, Year) <b>4/16 APR 17 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is devoted to a general survey of the situation in the country. It is a very interesting and informative study of the present state of affairs in the country.


2. The second part of the report is devoted to a detailed study of the various aspects of the situation in the country. It is a very thorough and comprehensive study of the various aspects of the situation in the country.

3. The third part of the report is devoted to a study of the various aspects of the situation in the country. It is a very thorough and comprehensive study of the various aspects of the situation in the country.

96 13183

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IOLA P. LARKINS				2. DATE OF DEATH MONTH DAY YEAR April 13, 1996		3. TIME OF DEATH 12:00 A M	
4. SOCIAL SECURITY NUMBER 079-34-6688		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 31, 1942	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) Chesapeake Manor Extended Care Ctr.		9b. CITY, TOWN OR LOCATION OF DEATH Arnold, Maryland		9c. COUNTY OF DEATH A. A. County	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1030 Lake Claire Drive				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		College (1-4 or 5 +) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Wife		16b. KIND OF BUSINESS/INDUSTRY Homemaker	
17. FATHER'S NAME (First, Middle, Last) Raymond Vitch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Pasquello			
19a. INFORMANT'S NAME (Type/Print) Margaret Vitch/Sister-In-Law				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 Lake Claire Drive Annapolis, MD 21401			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 4/17/96		20c. LOCATION — City or Town, State Brentwood, Maryland		22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HUNTINGTON'S CHOREA DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Scott Eden, MD				29c. LICENSE NUMBER D30701		29d. DATE SIGNED (Month, Day, Year) 4/13/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT SCOTT EDEN, M.D., 600 RIDGELY AVE, ANNAPOLIS, MD 21401							
31. DATE FILED (Month, Day, Year) APR 22 1996		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #1 AH  
4-22-96

96 13184

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>LORENS</u> <u>LILLIAN CARRICK LORENS</u>				2. DATE OF DEATH MONTH <u>17</u> DAY <u>14</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>2:05PM</u> M					
4. SOCIAL SECURITY NUMBER <u>212-74-3280</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>90</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Dec 30 1905</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Annapolis Nursing &amp; Rehab Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Annapolis</u>			9c. COUNTY OF DEATH <u>Anne Arundel</u>				
10a. STATE <u>MD</u>		10b. COUNTY <u>Anne Arundel</u>		10c. CITY, TOWN OR LOCATION <u>Annapolis</u>			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER <u>302 A Forbes Street</u>				10f. ZIP CODE <u>21401</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>					
17. FATHER'S NAME (First, Middle, Last) <u>Edwin Davis Carrick</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Virginia Gaither</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Thomas Wayson/Cousin</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>P.O. Box 3326 Annapolis, MD 21403</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Cedar Bluff Cemetery 4/19/96</u>		20c. LOCATION — City or Town, State <u>Annapolis, Maryland</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>John M. Taylor Funeral Home</u> <u>147 Duke Of Gloucester St. Annapolis, MD</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Plasma Cell Cancer</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Age.</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Home: <input type="checkbox"/> Nursing Home: <input type="checkbox"/> Residence: <input type="checkbox"/> Other (Specify): <input type="checkbox"/>									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u>1</u> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>12476r</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/16/96</u>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>600 RIDGEWAY AVE, Annapolis</u>											
31. DATE FILED (Month, Day, Year) <u>APR 22 1996</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13185

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eva Virginia Lowe</b>				2. Date of Death Month <b>4</b> Day <b>13</b> Year <b>96</b>		3. Time of Death <b>1235PM</b>	
	4e. Facility Name (If not Institution, give street and number) <b>Northampton Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>216-02-3565</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 11, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>355 W. Patrick St.</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>own home</b>				
17. Father's Name (First, Middle, Last) <b>Elmer Young</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel May</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sandra Lowe / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3624 Basford Rd./ Frederick, Maryland</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular accident</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Kathleen W Stern MD</b>				29c. License number <b>D32073</b>		29d. Date signed (Month, Day, Year) <b>4/14/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kathleen W Stern MD 610 Ninth Ave, Brunswick, Md. 21716</b>								
31. Date filed (Month, Day, Year) <b>APR 17 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

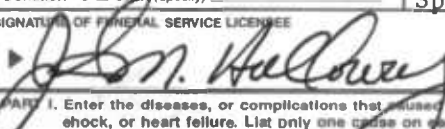






96 13186

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRIETTA MARIE MEILHAMMER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 3, 1996</b>		3. TIME OF DEATH <b>8:00 a m</b>	
4. SOCIAL SECURITY NUMBER <b>219-56-7988</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 4, 1950</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>6300 Feather Heights Dr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>6300 Feather Heights Dr.</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Storage Buildings</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry Donalds</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Bedsworth</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Steve a. Meilhammer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6300 Feather Heights Dr., Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens 4/5</b>		20c. LOCATION — City or Town, State <b>Hebron, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>			
23. a. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac Arrest</b> b. <b>Silicosis, Scleroderma, Cardomyopathy</b> c. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> d. <b>Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>MINS</b> <b>MTS</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 	
29c. LICENSE NUMBER <b>D10688</b>				29d. DATE SIGNED (Month, Day, Year) <b>4/4/96</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD M. WOOD 403 Quincy St., Salisbury, MD 21804 (410) 749-8906</b>	
31. DATE FILED (Month, Day, Year) <b>APR 04 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13187

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last) **GAY Lavonne McKinster**  
**GAY MCKINSTER**

2. Date of Death

Month  
**APR**Day  
**21**Year  
**1996**

3. Time of Death

**1949**4a. Facility Name (If not institution, give street and number)  
**UNIVERSITY OF MARYLAND**4b. City, Town, or Location of Death  
**BALTIMORE**

4c. County of Death

**Baltimore**Funeral  
Director5. Social Security Number  
**219-60-4464**6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
**42** Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
**June 6, 1953**9. Birthplace (State or Foreign  
Country)  
**Maryland**

Usual Residence of Decedent

10a. State

**Maryland**

10b. County

**Washington**

10c. City, Town or Location

**Hagerstown**

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

**17810 Greentree Terrace**

10f. Zip Code

**21740**

10g. Citizen of What Country?

**U.S.A.**

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: **White**15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

**12 years**

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)**Social Services**

16b. Kind of Business/Industry

**Local Government**

17. Father's Name (First, Middle, Last)

**Elmer Leroy Borgan**

18. Mother's Name (First, Middle, Maiden Surname)

**Anna Elizabeth Nalls**

19a. Informant's Name/Relationship (Type, Print)

**Stephanie Lapole**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**17810 Greentree Terrace Hagerstown, Md. 21740**

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)**Smithsburg Crematory April 24, 1996 Smithsburg, Maryland**

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

**Douglas A. Fiery Funeral Home****1331 Eastern Blvd. North Hagerstown, Md. 21742**23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. **Aortic Valve Endocarditis****10 days**

Due to (or as a consequence of):

b. **INFECTED Aortic IMPLANTED CARDIAC DEFIBRILLATOR** **10 days**

Due to (or as a consequence of):

c. **Aortic Valve Replacement**

Due to (or as a consequence of):

d. **Extension of DEFIBRILLATOR**Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

**046015**

29d. Date signed (Month, Day, Year)

**APR 21 1996**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DOUGLAS WALLACE, DEPT OF SURGERY, UNIVERSITY OF MARYLAND  
22 S. GREENE ST. BALTIMORE, MD.**

31. Date filed (Month, Day, Year)

**APR 23 1996**

32. Registrar's Signature

**John Andrew Randall**State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13188

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES WILLIAM MORLOCK, SR.				2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 1:10 pm	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL GENERAL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 219-18-7657		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 16, 1925	
	9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent 10e. State: MARYLAND 10b. County: CARROLL 10c. City, Town or Location: TANEYTOWN 10d. Inside City Limits: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Zip Code 21787		10g. Citizen of What Country? USA	
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Dates: WORLD WAR II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: CAUCASIAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collegia (1-4or 5+) 4 YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER/ STATE OF MD. ROADS		16b. Kind of Business/Industry GOVERNMENT			
	17. Father's Name (First, Middle, Last) JOHN ADAM MORLOCK				18. Mother's Name (First, Middle, Maiden Surname) LILLY PEARL GREENWOOD			
	19. Informant's Name/Relationship (Type, Print) CHARLES WILLIAM MORLOCK, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3979 HARNEY ROAD TANEYTOWN, MARYLAND 21787			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY LUTHERAN CEMETERY 4/24/96		20c. Location - City or Town, State TANEYTOWN, MARYLAND			
	21. Signature of Funeral Service Licensee P. Kevin Judy		22. Name and Address of Facility 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MARYLAND 21787					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute MI Due to (or as a consequence of): b. Coronary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 hr 20 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier John M. Lehigh				29c. License number D20330		29d. Date signed (Month, Day, Year) APRIL 22, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN M. LEHIGH, M.D. 104 NORTH MAIN STREET UNION BRIDGE, MARYLAND 21791							
31. Date filed (Month, Day, Year) APR 22 1996				32. Registrar's Signature John Davidson Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 13189

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT J. MCNEELY</b>				2. Date of Death Month <b>4</b> Day <b>19</b> Year <b>96</b>		3. Time of Death <b>9:30PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2708 Yeomans Lantern Court</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>122-01-1388</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 3, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2708 Yeomans Lantern Court</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>owner</b>		16b. Kind of Business/Industry <b>Service Station</b>			
	17. Father's Name (First, Middle, Last) <b>Edward J. McNeely</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Benson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mildred J. McNeely</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2708 Yeomans Lantern Ct. Annapolis, Maryland 21401</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		20c. Location - City or Town, State <b>04/21/96 Brentwood, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John M. Taylor Funeral Home Inc. 147 Duke of Gloucester st. Annapolis, Maryland</b>			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC SMALL CELL LUNG CANCER 10 MONTHS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D16354</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>E.W. COLE III 900 BESTGATE RD ANNAP. MD 21401</b>								
31. Date filed (Month, Day, Year) <b>APR 22 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13190

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA MATTHEWS MARINER</b> <i>Virginia Mariner</i>				2. Date of Death Month <b>April</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>11:48</b>	
	4a. Facility Name (If not institution, give street and number) <b>Levindale Hebrew Geriatric Center &amp; Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>219-14-4490</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 21, 1925</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Fruitland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>200 Sand Castle Blvd.</b>				10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Domestic</b>		
17. Father's Name (First, Middle, Last) <b>Elton Isaac Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Montrue Flossie Skeeter</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorsey W. Mariner/Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Sand Castle Blvd., Fruitland, MD 21826</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		Data <b>4/18/96</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee <i>David H. Thompson</i>				22. Name and Address of Facility <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ovarian CARCINOMA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>11/95</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Rha Wetherman</i>		29c. License number <b>D23767</b>		29d. Date signed (Month, Day, Year) <b>April 15, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DEBRA S WERTHEIMER, MD 2434 W. Belvedere Ave., Balt. MD 21215</b>								
31. Date filed (Month, Day, Year) <b>APR 17 1996</b>		32. Registrar's Signature <i>John Shuckler-Radell</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

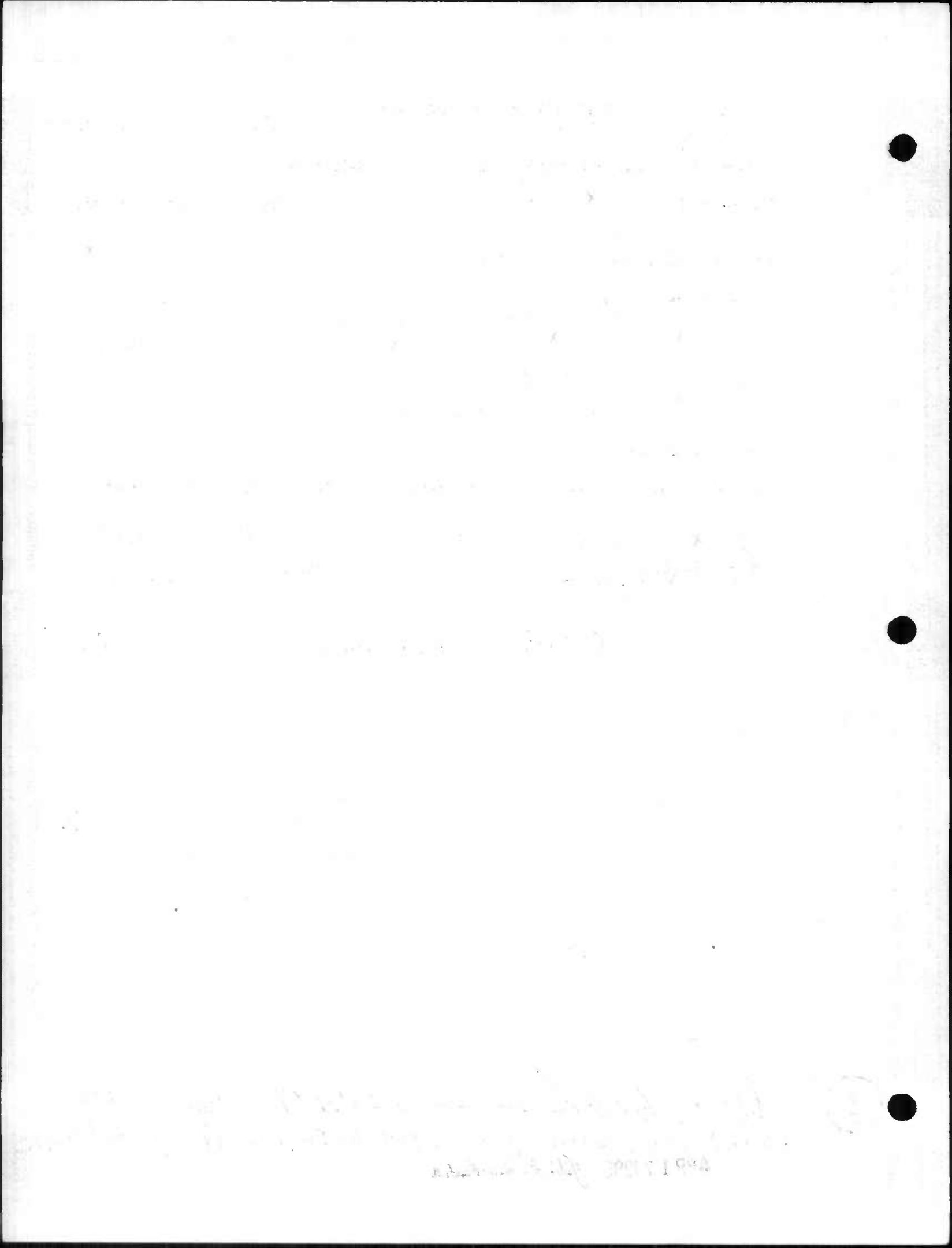
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9058.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13191

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH WHITMAN MACINNIS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>17</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>088-07-8701</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-14-09</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BERLIN NURSING &amp; REHAB. CTR.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BERLIN</b>		9c. COUNTY OF DEATH <b>WORCESTER</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>139 N. PARK DRIVE</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN FRANKLIN WHITMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH MAWSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BONNIE FARSKAFALVY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>139 N. PARK DR., SALISBURY, MD., 21801</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. LOCATION — City or Town, State <b>4-18 SALISBURY, MD.</b>		20d. DATE <b>4-18</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Ullrich</i>				22. NAME AND ADDRESS OF FACILITY <b>ULLRICH FUNERAL HOME BERLIN, MD., 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute coronary occlusion</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>None</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's disease</b> <b>Septicemia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Federico G. Arthes</i>				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>April</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FEDERICO G. ARTHESE, MD 1622A OCEAN PINES BERLIN MD 21811 410-641-4400</b>							
31. DATE FILED (Month, Day, Year) <b>APR 22 1996</b>				32. REGISTRAR'S SIGNATURE <i>John A. Ullrich</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13192

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lewis N. Miles</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 11 1996</b>		3. TIME OF DEATH <b>5:40 a. M</b>	
4. SOCIAL SECURITY NUMBER <b>214-42-8839</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 17, 1943</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
11. COUNTY OF DEATH <b>Wicomico</b>				12. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Worcester</b> 10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b> 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. STREET AND NUMBER <b>P.O. Box 263</b>	
14. ZIP CODE <b>21851</b>				15. CITIZEN OF WHAT COUNTRY? <b>USA</b>		16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
19. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>10th</b> College (1-4 or 5+) <b></b>			
21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Military/Disable</b>				22. KIND OF BUSINESS/INDUSTRY <b>Military</b>			
23. FATHER'S NAME (First, Middle, Last) <b>Winfred Johnson</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gladys Horsey</b>			
25. INFORMANT'S NAME (Type/Print) <b>Sharon Miles</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 263, Pocomoke City, Maryland</b>			
27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Maryland Veterans Cemetery 4/22/96 Beulah, Md.</b>			
29. SIGNATURE OF FUNERAL SERVICE LICENSEE 				30. NAME AND ADDRESS OF FACILITY <b>Bennie Smith Funeral Home 819 4th Street, Pocomoke City, Maryland</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				Approximate Interval Between Onset and Death			
a. <b>End Stage Renal Disease</b>				5 years			
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Chronic Glomerulonephritis</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Hypertension</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>Recurrent peritonitis due to peritoneal catheter for dialysis</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28. DATE OF INJURY (Month, Day, Year) <b></b>			
29. TIME OF INJURY <b>M</b>				29c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>				29d. DESCRIBE HOW INJURY OCCURRED <b></b>			
29e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>				29f. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Shrestha M.D.</b>				29c. LICENSE NUMBER <b>D16278</b>			
29d. DATE SIGNED (Month, Day, Year) <b>4.11.96</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Shrestha, M.D. PO Box 2018, Salisbury, MD 21802-2018</b>			
31. DATE FILED (Month, Day, Year) <b>APR 16 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




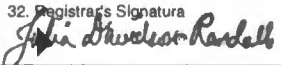
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13193

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GRETCHEN BRATE</b>			2. Date of Death Month <b>April</b> Day <b>5th</b> Year <b>1996</b>			3. Time of Death <b>2215</b>		
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>126-20-3208</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 30, 1913</b>		9. Birthplace (State or Foreign Country) <b>LAKE MONT, NY</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>M.D.</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1524F SHAREN DRIVE</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) <b>HARRY S. BRATE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ADELINE WARD CHADWICK</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>BARBARA C. HARTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31955 BON HILL DR. SALISBURY, MD. 21804</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>4-8-96 SALISBURY, MD.</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD. SALISBURY, MD. 21804</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Malignant Melanoma</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 			29c. License number <b>030690</b>			29d. Date signed (Month, Day, Year) <b>Apr. 6, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.</b>									
31. Date filed (Month, Day, Year) <b>APR 09 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

100-20

100-30

100-40 100-50 100-60 100-70 100-80 100-90

100

100-100

100-110

100-120

100-130

100-140

100

100

100-150

100-160 100-170 100-180 100-190

100-200 100-210 100-220 100-230 100-240

100-250 100-260 100-270 100-280 100-290

100-300 100-310 100-320 100-330 100-340

100-350 100-360 100-370 100-380 100-390 100-400

100-410 100-420 100-430 100-440 100-450

100-460

100-480 100-490 100-500

100

100

100-510 100-520 100-530 100-540 100-550





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13194

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOWARD MILLS</b>		2. Date of Death Month Day Year <b>APRIL 3, 1996</b>		3. Time of Death <b>10:50 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>		4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>
Funeral Director	5. Social Security Number <b>220-07-7806</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1919</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Delaware</b>		10b. County <b>Sussex</b>
	10c. City, Town or Location <b>Seaford</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>Locust Street</b>		10f. Zip Code <b>19973</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>
	16b. Kind of Business/Industry <b>DuPont Nylon Co.</b>		17. Father's Name (First, Middle, Last) <b>Marion Mills</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Smith</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Terri Johnson - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 1056 Locust St. Seaford, DE. 19973</b>		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cambridge Crematory</b>		20c. Location - City or Town, State <b>4-6-96 Cambridge, MD.</b>
	21. Signature of Funeral Service Licensee <i>William M. Short</i>		22. Name and Address of Facility <b>Short Funeral Home, Inc. 700 West Street Laurel, DE. 19956</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Sudden Death - Suspect Aspiration</b> Due to (or as a consequence of): b. <b>Strokes / HTN.</b> Due to (or as a consequence of): c. <b>Seizures.</b> Due to (or as a consequence of): d. <b>Renal Failure</b>		Approximate Interval Between Onset and Death <b>4/3/96</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DM - slp subdural Hematoma</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William M. Short</i>		29c. License number <b>D-29349</b>	
29d. Date signed (Month, Day, Year) <b>4/5/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>			
31. Date filed (Month, Day, Year) <b>APR 05 1996</b>		32. Registrar's Signature <i>John Davidson Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

10. *Journal of the American Statistical Association*, 1997, 92, 1003-1012.

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96 13195

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Gibson McGehee				2. DATE OF DEATH MONTH DAY YEAR April 22, 1996		3. TIME OF DEATH 8:00 A. M.	
4. SOCIAL SECURITY NUMBER 260-60-2035		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 4, 1910	
8. BIRTHPLACE (State or Foreign Country) Georgia				9a. FACILITY NAME (If not institution, give street and number) 310 Lore Court		9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Lexington Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 310 Lore Court	
10f. ZIP CODE 20653				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commissioned Officer		16b. KIND OF BUSINESS/INDUSTRY U.S. Navy	
17. FATHER'S NAME (First, Middle, Last) James Augustus McGehee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lelia Amanda Gibson			
19a. INFORMANT'S NAME (Type/Print) George E. Clarke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Lore Court, Lexington Park, Maryland 20653			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/23/96		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Permanent Pacemaker</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James C. Boyd, M.D.</i>				29c. LICENSE NUMBER D/9917		29d. DATE SIGNED (Month, Day, Year) 4/23/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James C. Boyd, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) APR 24 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13196

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Paul Eugene MOBLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1996</b>		3. TIME OF DEATH <b>3:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-10-0954</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul 31, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Frederick</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Homewood Retirement Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>31 West Patrick Street</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering</b>		16b. KIND OF BUSINESS/INDUSTRY <b>I.B.M.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Lewis MOBLEY Sr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pleasant Veranda GURLEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Keith E. Mobley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9237 Oak Tree Circle, Frederick, Maryland 21701</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery Apr 15, 1996</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith E. Mobley</i> <b>MO0706</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>2 YEARS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Neil V. Waravdekar MD</i>				29c. LICENSE NUMBER <b>D 47611</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Neil V. Waravdekar MD 1475 Taney Avenue, Frederick, Maryland 21702</b>							
31. DATE FILED (Month, Day, Year) <b>APR 15 1996</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, at item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13197

AMENDED ITEM # 7 WCHD 04/05/96 PJS

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leila McCowan</b>				2. Date of Death Month <b>March</b> Day <b>31</b> Year <b>1996</b>		3. Time of Death <b>4:50 A.M.</b>									
	4a. Facility Name (If not Institution, give street and number) <b>Salisbury Center: Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>									
Funeral Director	5. Social Security Number <b>264-38-2067</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 1, 1905</b>		9. Birthplace (State or Foreign Country) <b>Georgia</b>								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <b>420 Hastings St.</b>			10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Health Care</b>										
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>Irene Lee</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>420 Hastings St., Salisbury, MD 21801</b>											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Mem. Gardens</b>		20c. Date <b>4/4/96</b>		20d. Location - City or Town, State <b>Hebron, MD</b>									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home</b> <b>1618 West Rd., Salisbury, MD 21801</b>											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Coronary artery disease</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>yes</b></td> </tr> <tr> <td>b. <b>Pericardial disease</b> Due to (or as a consequence of):</td> <td><b>yes</b></td> </tr> <tr> <td>c. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of):</td> <td><b>yes</b></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Coronary artery disease</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>yes</b>	b. <b>Pericardial disease</b> Due to (or as a consequence of):	<b>yes</b>	c. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of):	<b>yes</b>	d. _____
Immediate Cause (Final disease or condition resulting in death)	a. <b>Coronary artery disease</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>yes</b>														
	b. <b>Pericardial disease</b> Due to (or as a consequence of):	<b>yes</b>														
	c. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of):	<b>yes</b>														
	d. _____															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
		28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>029349</b>		29d. Date signed (Month, Day, Year) <b>4/1/96</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William H. Robins, 1104 Healthway Dr., Salisbury, MD 21801</b>																
31. Date filed (Month, Day, Year) <b>APR 02 1996</b>		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPHINE T. MARIANI</b>				2. Date of Death Month <b>APRIL</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>1215</b>							
	4a. Facility Name (If not Institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>							
Funeral Director	5. Social Security Number <b>051-20-0174</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3-21-23</b>							
	9. Birthplace (State or Foreign Country) <b>PA.</b>		10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>OCEAN CITY</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number <b>110 WINTER HARBOR DRIVE</b>				10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES REPRESENTATIVE</b>		16b. Kind of Business/Industry <b>RETAIL</b>									
	17. Father's Name (First, Middle, Last) <b>PETER PIKULSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELENA MERCIK</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>PAUL MARIANI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>110 WINTER HARBOR DR., OCEAN CITY, MD., 21842</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. CHARLES CEMETERY 4-23</b>		20c. Location - City or Town, State <b>PINELAWN, NY</b>									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Brain Tumor</u></td> <td rowspan="4">           Due to (or as a consequence of):             b. <u>instability to eat</u>             c.             d.         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <u>unknown</u> </td> </tr> <tr><td>b.</td></tr> <tr><td>c.</td></tr> <tr><td>d.</td></tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Brain Tumor</u>	Due to (or as a consequence of):  b. <u>instability to eat</u>  c.  d.	Approximate Interval Between Onset and Death  <u>unknown</u>	b.	c.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Brain Tumor</u>	Due to (or as a consequence of):  b. <u>instability to eat</u>  c.  d.	Approximate Interval Between Onset and Death  <u>unknown</u>											
	b.													
	c.													
	d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
		28d. Describe how injury occurred		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 				29c. License number <b>H43617</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>								
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>SCOTT SWEENEY DO 11220 BEAUCHAMP RD BERLIN, MD 21811</b>														
31. Date filed (Month, Day, Year) <b>APR 22 1996</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

APR 22 1996

Julia Davidson Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13199

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUBY LEE Noland		2. Date of Death Month Day Year April 4 1996		3. Time of Death 1020
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 237-16-0805	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) November 21, 1912		9. Birthplace (State or Foreign Country) North Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Wicomico
	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 30200 Stoneybrook Drive		10f. Zip Code 21804		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry General Sales		
	17. Father's Name (First, Middle, Last) William Brown		18. Mother's Name (First, Middle, Maiden Surname) Luster Carson		
	19a. Informant's Name/Relationship (Type, Print) David Noland		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30200 Stoneybrook Dr., Salisbury, MD 21804		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State Salisbury, MD
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Heart Disease				2 yrs.
	Due to (or as a consequence of): Generalized Atherosclerosis				5 yrs.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia, Alzheimer's Type Hypothyroidism, Depression				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number D 29505	
29d. Date signed (Month, Day, Year) 4-4-96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. 4421 BEECHWOOD PLACE, CRISFIELD, MD 21817			
31. Date filed (Month, Day, Year) APR 09 1996		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9028.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 13200

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13201

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AVERY W. OWENS</b>				2. Date of Death Month Day Year <b>April 12 1996</b>				3. Time of Death <b>12:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>				4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>219-05-9557</b>		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) <b>June 18, 1915</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		Usual Residence of Decedent		10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		
To Be Completed by Funeral Director	10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>1002 Beaglin Park Dr. Apt. 202</b>		
	10f. Zip Code <b>21804</b>				10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Timber Purchasing Agent</b>				16b. Kind of Business/Industry <b>Pulp Wood</b>		
	17. Father's Name (First, Middle, Last) <b>Samuel W. Owens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertie Jones Owens</b>				19a. Informant's Name/Relationship (Type, Print) <b>Doris Owens</b>		
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1002 Beaglin Park Dr. Apt. 202 Salisbury, Md. 21804</b>				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Firemen's Cemetery</b>		
	20c. Date <b>4-14</b>				20d. Location - City or Town, State <b>Sharptown, Md.</b>				21. Signature of Funeral Service Licensee <i>William M. Short</i>		
	22. Name and Address of Facility <b>Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Glioblastoma Multiforme</b> Due to (or as a consequence of): <b>b. Parkinson Ds</b> Due to (or as a consequence of): <b>c. Seizure Ds</b> Due to (or as a consequence of): <b>d. BPH.</b>				Approximate Interval Between Onset and Death <b>12/95</b>		
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Michael Atkins</i>				29c. License number <b>D-39813</b>			
29d. Date signed (Month, Day, Year) <b>4/12/96</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, Md. 21804</b>				31. Date filed (Month, Day, Year) <b>APR 15 1996</b>			
32. Registrar's Signature <i>John Andrew Randall</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 13202

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vilma Elise Oglesby</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1996</b>		3. TIME OF DEATH <b>9:00 A. M</b>	
4. SOCIAL SECURITY NUMBER <b>135-22-6940</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>October 14, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>				9. COUNTY OF DEATH <b>St. Mary's</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>		9c. COUNTY OF DEATH <b>St. Mary's</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>St. Mary's</b>		10c. CITY, TOWN OR LOCATION <b>Leonardtwn</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 1, Box 94</b>				10f. ZIP CODE <b>20650</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Hans Bungenstab</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elise Delle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William M. Oglesby</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1, Box 94, Leonardtown, Maryland 20650</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Vail Cemetery</b>		20c. LOCATION — City or Town, State <b>4-29-96 Parsippany, New Jersey</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> <b>Edward N. Brinsfield, Jr., MD0052</b>	
22. NAME AND ADDRESS OF FACILITY <b>Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>YES,</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II</i>				29c. LICENSE NUMBER <b>D14285</b>		29d. DATE SIGNED (Month, Day, Year) <b>26 April 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650-1753</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13203

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>PERRY CURTIS ORNDORFF JR.</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>13</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>10:04 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-24-6058</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 27, 1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>525 Mary Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Frederick</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>525 Mary Street</b>	
10f. ZIP CODE <b>21701</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (6-12)</b> <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Monument Cutter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Monument Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Perry Curtis Orndorff Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Rinehart</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty L. Orndorff</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>525 Mary Street, Frederick, Maryland 21701</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		DATE <b>4/16</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Broncho pneumonia</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>extensive esophagitis</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>014626</b>		29d. DATE SIGNED (Month, Day, Year) <b>APR-15, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>P. Gregory Rausch, MD 501 West Seventh Street, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 15 1996</b>		32. REGISTRAR'S SIGNATURE 					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13204

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVAN T. POPE</b>				2. Date of Death Month <b>April</b> Day <b>8</b> Year <b>1996</b>				3. Time of Death <b>6:00pm</b>	
	4e. Facility Name (If not Institution, give street and number) <b>Hyattsville Health Care Center</b>				4b. City, Town, or Location of Death <b>Hyattsville</b>				4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>211-20-1307</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 7, 1926</b>		9. Birthplace (State or Foreign Country) <b>unknown</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>unknown</b>		10b. County <b>unknown</b>		10c. City, Town or Location <b>unknown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>unknown</b>				10f. Zip Code <b>unknown</b>				10g. Citizen of What Country? <b>unknown</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>				16b. Kind of Business/Industry <b>unknown</b>	
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Nathan Pope/brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>State rem.</b>		Data		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Joseph B. Vign Sant</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediata Cause (Final disease or condition resulting in death) a. <b>Aids</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Cardiopulmonary Failure</b> Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how Injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Robert D. Skipworth MD</b>										
29c. License number <b>MD. D 28906</b>										
29d. Date signed (Month, Day, Year) <b>April 8th, 1996</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>304 Oregon Ct. Severna Park, MD. 21144</b>										
31. Date filed (Month, Day, Year) <b>APR 06 1996</b>										
32. Registrar's Signature <b>Davidson-Randall</b>										

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13205

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roxie Lee Painter</b>				2. Date of Death Month <b>April</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>0955 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>232-32-0984</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 26, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>WV.</b>		10b. County <b>Fayette</b>		10c. City, Town or Location <b>Dothan</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Rt. 612</b>		10f. Zip Code <b>25833</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Hilmer Porter Webb</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Della Mae Kearns</b>		19a. Informant's Name/Relationship (Type, Print) <b>Rudy Painter (Son)</b>			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Joy St. Oak Hill, WV. 25901</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>High Lawn Memorial Park</b>		20c. Location - City or Town, State <b>Apr. 20, 96 Oak Hill, WV.</b>	
	21. Signature of Funeral Service Licensee <b>Pennis R. Davis</b>		22. Name and Address of Facility <b>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>2 1/2 weeks</b> <b>2 1/2 weeks</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Jacobsonell</b>		29c. License number <b>D 47942</b>		29d. Date signed (Month, Day, Year) <b>April 17, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Juan A. Carbonell 12931 Oak Hill Ave. Hagerstown, Md. 21740</b>		31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature <b>Johanna...</b>			

1990-1991



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13206

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES LOUISE PLUMMER

2. Date of Death

April 18 1996 5:45 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-46-1494

8. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 2, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1138 Oak Hill Avenue

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

James Metzgar

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Stutzman

19a. Informant's Name/Relationship (Type, Print)

Walter Plummer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1138 Oak Hill Avenue, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery 04/22/96

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. North, Hagerstown, MD 21742

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Asystole and electromechanical dissociation

10-15 mins

Due to (or as a consequence of):

b. Dilated cardiomyopathy with severe right and left heart failure

3 years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. ① Ischemia and coronary artery disease and ② chronic obstructive pulmonary disease

at least 5 years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic atrial fibrillation

chronic left bundle branch block

Urinary tract infection

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Nursing home part of hospital, extended care facility

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury death

4/18/96

28b. Time of injury death

5:45 AM

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott M. Hamilton, MD

29c. License number

D44316

29d. Date signed (Month, Day, Year)

4/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

354 Hill Street, Hagerstown, Maryland 21740

Scott M. Hamilton, MD

31. Date filed (Month, Day, Year)

APR 23 1996

32. Registrar's Signature

John Anderson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13207

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GRACE E. PYLES</b>				2. Date of Death Month <b>4</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>9:25</b>		
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>		
Funeral Director	5. Social Security Number <b>218-30-3405</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7-22-12</b>		
	10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BERLIN</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>64 BATTERSEA RD.</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		18b. Kind of Business/Industry <b>OWN HOME</b>			
17. Father's Name (First, Middle, Last) <b>WILLIAM D. DION</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE A. DEE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>HOWARD W. PYLES</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>815 OCEAN PINES BERLIN, MD., 21811</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		Date <b>4-19</b>		20c. Location - City or Town, State <b>SALISBURY, MD.</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CRITICAL AORTIC STENOSIS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>&gt; 3 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiomyopathy with congestive heart failure</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number <b>D 42083</b>		29d. Date signed (Month, Day, Year) <b>4-17-96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GUNTA A WOODS HD 9633 Woodbury Dr, BERLIN MD 21811</b>									
31. Date filed (Month, Day, Year) <b>4-17 APR 22 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

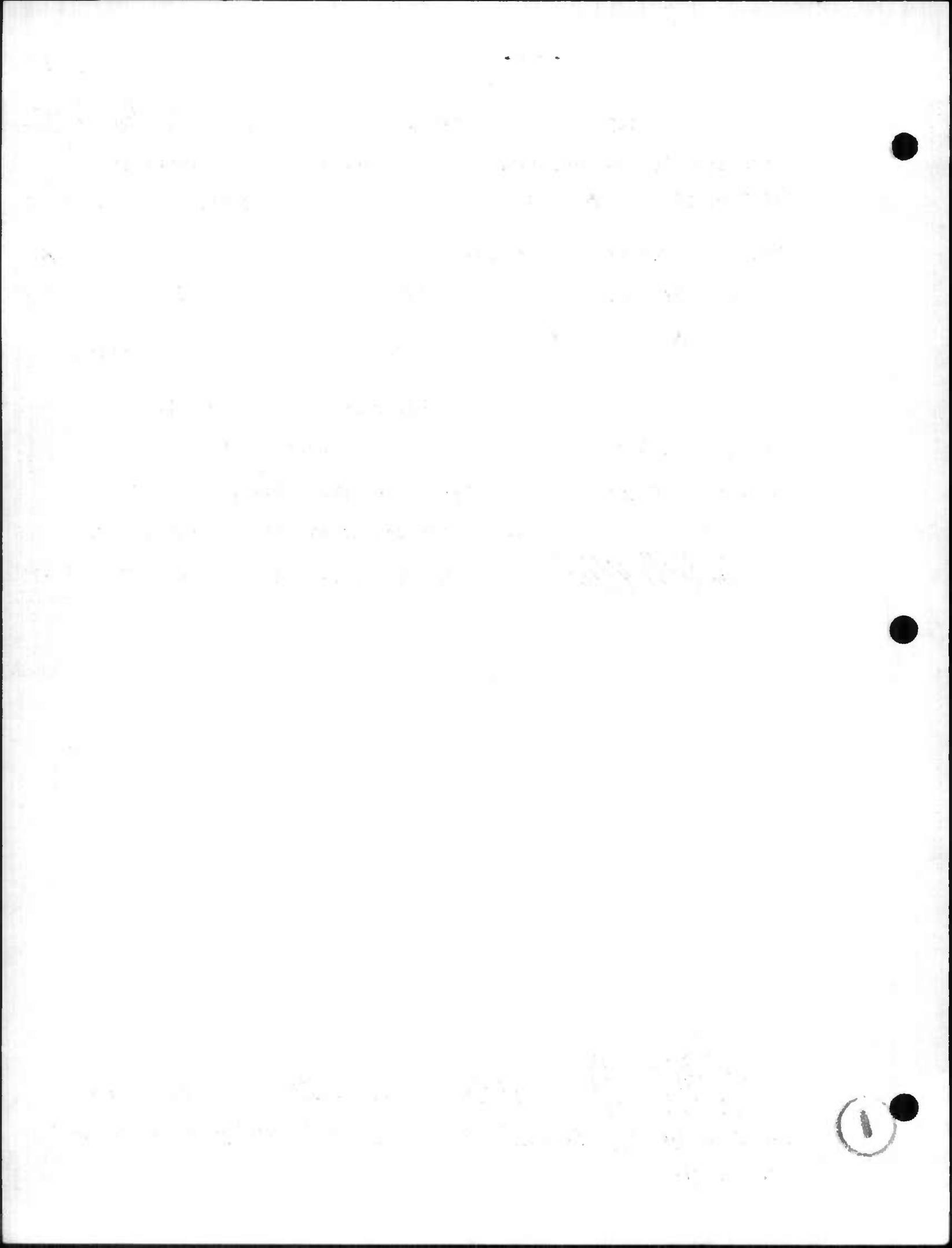
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13208

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Chester L. Pope

2. Date of Death

April 4 1996

3. Time of Death

4 30 pm

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

OKLAHOMA

5. Social Security Number

442-36-8599

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 20, 1936

9. Birthplace (State or Foreign Country)

OKLAHOMA

Usual Residence of Decedent

10a. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

FRUITLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

208 SCHOOL STREET

10f. Zip Code

21826

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: KOREA  
NAVY

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RET. U.S. NAVY

16b. Kind of Business/Industry

U.S. GOV'T

17. Father's Name (First, Middle, Last)

LAYMAN POPE

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE LASHBROOK

19a. Informant's Name/Relationship (Type, Print)

JOANNE POPE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 SCHOOL STREET, FRUITLAND, MD. 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRINGHILL MEM. GDNS

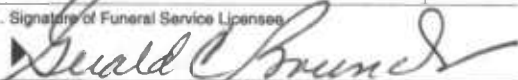
Date

4/10

20c. Location - City or Town, State

HEBRON, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

BOUNDS FUNERAL HOME, SALISBURY, MD. 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic small cell lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 mo

29c. License number

P00974

29d. Date signed (Month, Day, Year)

April 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle A. Juaneza Univ. of Maryland 22 S. Greene St. Balto. MD 21201

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

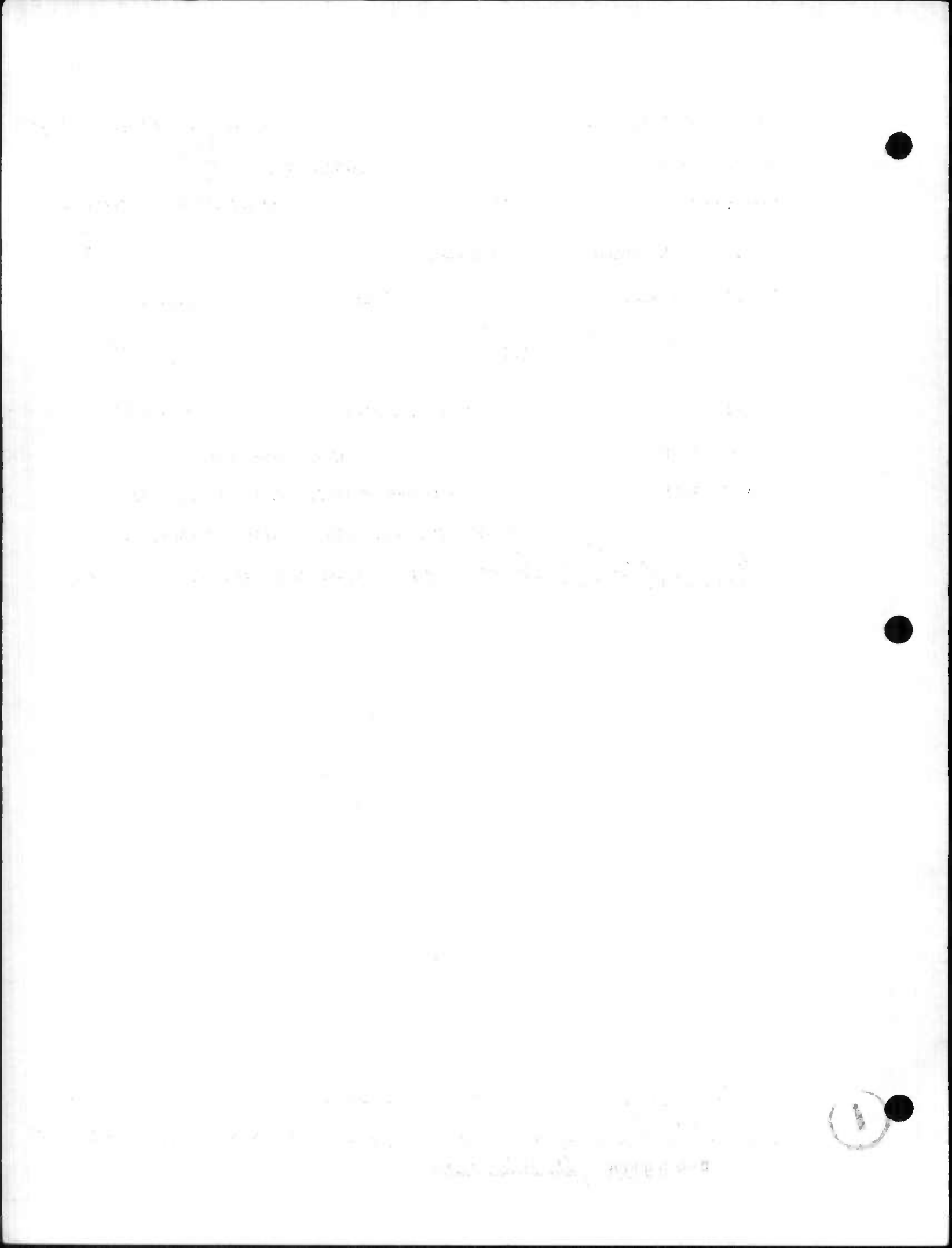
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13209

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Florence Elizabeth Pickett</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>17</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>217-12-2788</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 16, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1730 West Old Liberty Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Westminster</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1730 West Old Liberty Road</b>				10f. ZIP CODE <b>21157</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 years</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Beautician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beauty Shop</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jacob E. Summers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mamie B. Carter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Francis Pickett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1730 West Old Liberty Rd., Westminster, Maryland 21157</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Lake View Memorial Park 4/19/96</b>		20c. LOCATION — City or Town, State <b>Sykesville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert W. Keeney #M00652</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney &amp; Basford P.A. Funeral Home 106 E. Church St., Frederick, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA OF THE COLON</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate interval Between Onset and Death <b>18 MONTHS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Brian M. O'Conner, MD</b>				29c. LICENSE NUMBER <b>D31761</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/17/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Brian M. O'Conner 501 West 7th Street, Frederick, Md. 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 18 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 13210**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>JOYCE ANN Powell</b>				2. Date of Death Month <b>April</b> Day <b>13</b> Year <b>1996</b>				3. Time of Death <b>0750</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>				4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>217-30-9477</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 27 1932</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street end Number <b>31619 OLD OCEAN CITY ROAD</b>				10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPER</b>			16b. Kind of Business/Industry <b>STATE HOSPITAL</b>		
	17. Father's Name (First, Middle, Last) <b>THOMAS SMALLWOOD</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>LUCY ELLIOTT</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>JACK STANLEY</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 SNOW HILL ROAD, SALISBURY, MD. 21801</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK</b>		Data <b>4/16</b>		20c. Location - City or Town, State <b>SALISBURY, MD.</b>			
	21. Signature of Funeral Service Licensee <i>Gerald C. Bruner</i>				22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hepatic Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Paul R. Higgins</i>				29c. License number <b>D24872</b>		29d. Date signed (Month, Day, Year) <b>4/13/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>560 RIVERSIDE DR 204A SALISBURY MD 21801</b>										
31. Date filed (Month, Day, Year) <b>APR 15 1996</b>				32. Registrar's Signature <i>John Andrew Randall</i>						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

2001 6 1 894



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 13211  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <i>Bernice Marilyn Robertson</i>		2. Date of Death Month <i>April</i> Day <i>22</i> Year <i>1996</i>		3. Time of Death <i>1345 P</i>		
4a. Facility Name (If not Institution, give street and number) <i>WASHINGTON COUNTY HOSPITAL</i>			4b. City, Town, or Location of Death <i>HAGERSTOWN</i>		4c. County of Death <i>WASHINGTON</i>	
5. Social Security Number <i>218-16-2926</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>APRIL 1, 1922</i>	
9. Birthplace (State or Foreign Country) <i>WEST VIRGINIA</i>						
Usual Residence of Decedent						
10a. State <i>MARYLAND</i>	10b. County <i>WASHINGTON</i>	10c. City, Town or Location <i>BOONSBORO</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>10 BOONE PLACE</i>		10f. Zip Code <i>21713</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. <i>WHITE</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>EXPEDITER</i>		16b. Kind of Business/Industry <i>AIRCRAFT MANUFACTURING</i>				
17. Father's Name (First, Middle, Last) <i>ERNEST EDGAR JONES</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>LEA NETTA RENNER</i>			
19a. Informant's Name/Relationship (Type, Print) <i>HAROLD M. ROBERTSON/SON</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10 PARK DRIVE, BOONSBORO, MARYLAND 21713</i>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>SMITHSBURG CREMATORY</i>		20c. Location - City or Town, State <i>SMITHSBURG, MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>Paul M. Dean</i>		22. Name and Address of Facility <i>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)		e. <i>Respiratory Failure</i> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <i>One week</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. <i>Emphysema</i> Due to (or as a consequence of):			<i>10 YEARS</i>	
c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
Congestive Heart Failure			23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Severe Degenerative Joint Disease			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>MD</i>				
29c. License number <i>D44996</i>		29d. Date signed (Month, Day, Year) <i>April 23, 1996</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ZAFAR MALIK 20311 LAPPANS RD BOONSBORO MD 21713.</i>						
31. Date filed (Month, Day, Year) <i>APR 24 1996</i>		32. Registrar's Signature <i>John Andrew Rickett</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

58 13212

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Elva Kennedy Runge</b>					2. Date of Death Month <b>April</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>1:02 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Long View Nursing Home</b>				4b. City, Town, or Location of Death <b>Manchester</b>		4c. County of Death <b>Carroll</b>			
<b>Funeral Director</b>	5. Social Security Number <b>214-14-2533</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 1, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>5959 Glen Falls Road</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Raymond Parks</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Ennis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Fran E. Geiwitz</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4600 Springdale Road, Millers, MD 21107</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>4/24</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Stevens W. Eline</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St, Hampstead, MD 21074</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Dementia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b></b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>Years</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of certifier <b>Stevens W. Eline</b>				29c. License number <b>253165</b>			29d. Date signed (Month, Day, Year) <b>4/22/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven Sharber MD 2111 Hanover Pike Hampstead MD 21074</b>										
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature <b>John Anderson-Randall</b>								

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

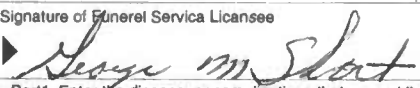
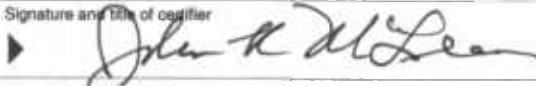
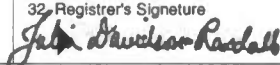
**State  
Registrar**



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13213

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MILDRED IRENE</b>				2. Date of Death Month <b>April</b> Day <b>14</b> Year <b>1996</b>				3. Time of Death <b>1830</b>			
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>				4c. County of Death <b>WICOMICO</b>			
<b>Funeral Director</b>	5. Social Security Number <b>410-44-4657</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-25-1930</b>		9. Birthplace (State or Foreign Country) <b>TENNESSEE</b>			
	10a. State <b>DELAWARE</b>				10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>BRIDGEVILLE</b>					
Usual Residence of Decedent												
10a. State <b>DELAWARE</b>				10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>BRIDGEVILLE</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>R.D.#2, box 63</b>					10f. Zip Code <b>19933</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSTRUCTOR</b>			16b. Kind of Business/Industry <b>visually impaired</b>				
17. Father's Name (First, Middle, Last) <b>STANTON CLIMER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>BESSIE E. DYCUS</b>							
19a. Informant's Name/Relationship (Type, Print) <b>JOHN REDLICH - HUSBAND</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>R.D. #2, BOX 63., BRIDGEVILLE, DE 19933</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ODD FELLOWS CEMETERY</b>			20c. Location - City or Town, State <b>4-17-96 MILFORD, DE</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>BERRY-SHORT FUNERAL HOME, 119 NW FRONT ST. MILFORD, DE 19963</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">e. <b>Acute anterior MI with cardiogenic shock</b></div><div style="width: 15%;">Approximate Interval Between Onset and Death <b>2 1/2 hours</b></div></div> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">b. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div> <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">c. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div> <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">d. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div>												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and Title of certifier 					29c. License number <b>D25209</b>			29d. Date signed (Month, Day, Year) <b>4/15/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN R. McLEAN, M.D. 106 SHILBEST ST 969 Salisbury, MD 21801</b>												
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>					32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**State  
Registrar**

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

1954

RECEIVED

FROM

DATE

BY

INITIALS

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BY

INITIALS

RECEIVED 1954



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State of Maryland / Department of Health and Mental Hygiene

96 13214

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>CONSTANCE PERRY RAYNE</b>			2. Date of Death Month <b>APRIL</b> Day <b>14</b> Year <b>1996</b>			3. Time of Death <b>1158</b>					
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>					
Funeral Director	5. Social Security Number <b>212-14-4978</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 12, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Wicomico</b> 10c. City, Town or Location <b>Salisbury</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>124 Holland Ave.</b>			10f. Zip Code <b>21801</b>			10g. Citizen of What Country? <b>USA</b>		
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Domestic</b>						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Richard A. Perry</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Madelyn Messick</b>			19a. Informant's Name/Relationship (Type, Print) <b>Barry Rayne</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30558 Old Fruitland Rd., Salisbury, MD 21801</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dennis Family Cemetery</b>			20c. Location - City or Town, State <b>Willards, MD</b>			20d. Date <b>4/17/96</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial infarct</b> Due to (or as a consequence of): <b>b. Cardiorespiratory shock</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>			Approximate Interval Between Onset and Death <b>day</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		
	28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <b>D29349</b>			29d. Date signed (Month, Day, Year) <b>4/16/96</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William H. Robins M.D. 1104 Healthway Dr. Salisbury Md.</b>			31. Date filed (Month, Day, Year) <b>APR 17 1996</b>			32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20015 1 703

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13215

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAE P. RICHARDSON</b>			2. Date of Death Month <b>April</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>1800</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>213-22-5805</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 5, 1912</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4637 SNOW HILL ROAD</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM W. MITCHELL</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY PRYOR</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BARBARA EVANS</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7009 SNOW HILL ROAD, SALISBURY, MD. 21804</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MITCHELL FAMILY CEM.</b>		Date <b>4/17</b>		20c. Location - City or Town, State <b>SALISBURY, MD.</b>
	21. Signature of Funeral Service Licensee <i>Gerald S. Bounds</i>		22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, SALISBURY, MARYLAND 21804</b>				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): b. <b>ACUTE VENTRICULOSEPTAL RUPTURE</b> Due to (or as a consequence of): c. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): d.						<b>48h</b> <b>48h</b> <b>72h</b>
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					28. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>Paul R. Hing</i>		29c. License number <b>024872</b>		29d. Date signed (Month, Day, Year) <b>4/13/94</b>		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5700 Riverdale DR SALISBURY MD 21807</b>						
	31. Date filed (Month, Day, Year) <b>APR 15 1996</b>		32. Registrar's Signature <i>John A. Buckner-Rodell</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

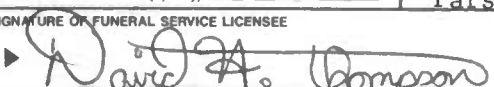

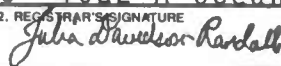
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96 13216

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carrie T Reddish</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>10</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>10:55 P</b>	
4. SOCIAL SECURITY NUMBER <b>216-54-9844</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 13, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Wicomico Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Rt. 2, Log Cabin Rd.</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Fred Twilley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nannie Disharoon</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nanetta Webster</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2, Box 124, Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parsons Cemetery 4/13</b>		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial infarct</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Coronary Artery Disease per Diffuse ASVD.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lt. Fracture.</b> <b>Family.</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 11 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.G. Arthes, MD 1622 A Ocean Pines, Md. 21811</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13217

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORMAN KENNETH REED</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>1759</b> M	
4. SOCIAL SECURITY NUMBER <b>155-42-6602</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 21, 1949</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>De</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Farmington</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>17 Main Street</b>				10f. ZIP CODE <b>Kent</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer &amp; Security Guard</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Modular Home Builder</b> <b>Nanticoke Homes</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lennus H. Benner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn (Reed)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hester Reed</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17 Main St., Farmington, De. 19942</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Johnstown</b>		DATE <b>4/4</b>		20c. LOCATION — City or Town, State <b>Greenwood, De.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas E. Melvin</i>				22. NAME AND ADDRESS OF FACILITY <b>Melvin Funeral Home</b> <b>15522 S. Dupont Hwy</b> <b>Herrington DE 19952</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						Approximate Interval Between Onset and Death	
a. <b>MYOCARDIAL INFARCTION</b>						<b>TWO HOURS</b>	
b. <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b>						<b>TEN YEARS</b>	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Enrico A. Gangeruso</i>				29c. LICENSE NUMBER <b>D44362</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 30, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Enrico A. Gangeruso, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13218

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Louise Rawlings</b>				2. Date of Death Month <b>April</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>0850 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>216 22 2386</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 9 1906</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10e. Street and Number <b>1120 Boyd Rawlings Road</b>		10f. Zip Code <b>20678</b>	
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Prince Frederick</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>white</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>housewife</b>		16b. Kind of Business/Industry <b>homemaker</b>		
17. Father's Name (First, Middle, Last) <b>John William Buckmaster</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Blanche Moore</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sandra L. Bowen / granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4185 Leitchs Wharf Rd. Prince Frederick Maryland 20678</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Pauls Episcopal Cemetery</b>		20c. Location - City or Town, State <b>Prince Frederick Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home 4405 Brookes Is. Rd. Port Republic Maryland 20678</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D-25435</b>		29d. Date signed (Month, Day, Year) <b>4/21/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mukesh Mathur, M.D., Prince Frederick, MD 20678</b>								
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the specific work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the financial statement of the year. It is a statement of the income and expenditure of the year. It is a statement of the income and expenditure of the year. It is a statement of the income and expenditure of the year.

4. The fourth part of the report deals with the general statement of the work done and the results obtained. It is a general statement of the work done and the results obtained. It is a general statement of the work done and the results obtained. It is a general statement of the work done and the results obtained.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13219

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Janice Laverne Snyder

2. Date of Death

Month Day Year  
April 20 1996

3. Time of Death

0530 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215 26 8062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 6, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

61 Randolph Ave.

10f. Zip Code

21740

10g. Chizan of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Clarence William Grimm

18. Mother's Name (First, Middle, Maiden Summa)

Julia Marie Snodderly

19a. Informant's Name/Relationship (Type, Print)

Clyde B. Snyder

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 Randolph Ave. Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

4/21/96

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

*Gerald N. Minnich*

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac  
Funeral Home Hagerstown, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Cardiopulmonary Arrest*

Due to (or as a consequence of):

*Respiratory Insufficiency*

Due to (or as a consequence of):

*Recurrent Congestive Heart Failure with Effusion*

Due to (or as a consequence of):

*Cardiomyopathy*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes Mellitus**Peripheral Vascular Disease  
multiple leg ulcers.*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Frank Andrade*

29c. License number

D27898

29d. Date signed (Month, Day, Year)

4/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

APR 22 1996

32. Registrar's Signature

*John H. Hager*State  
Registrar

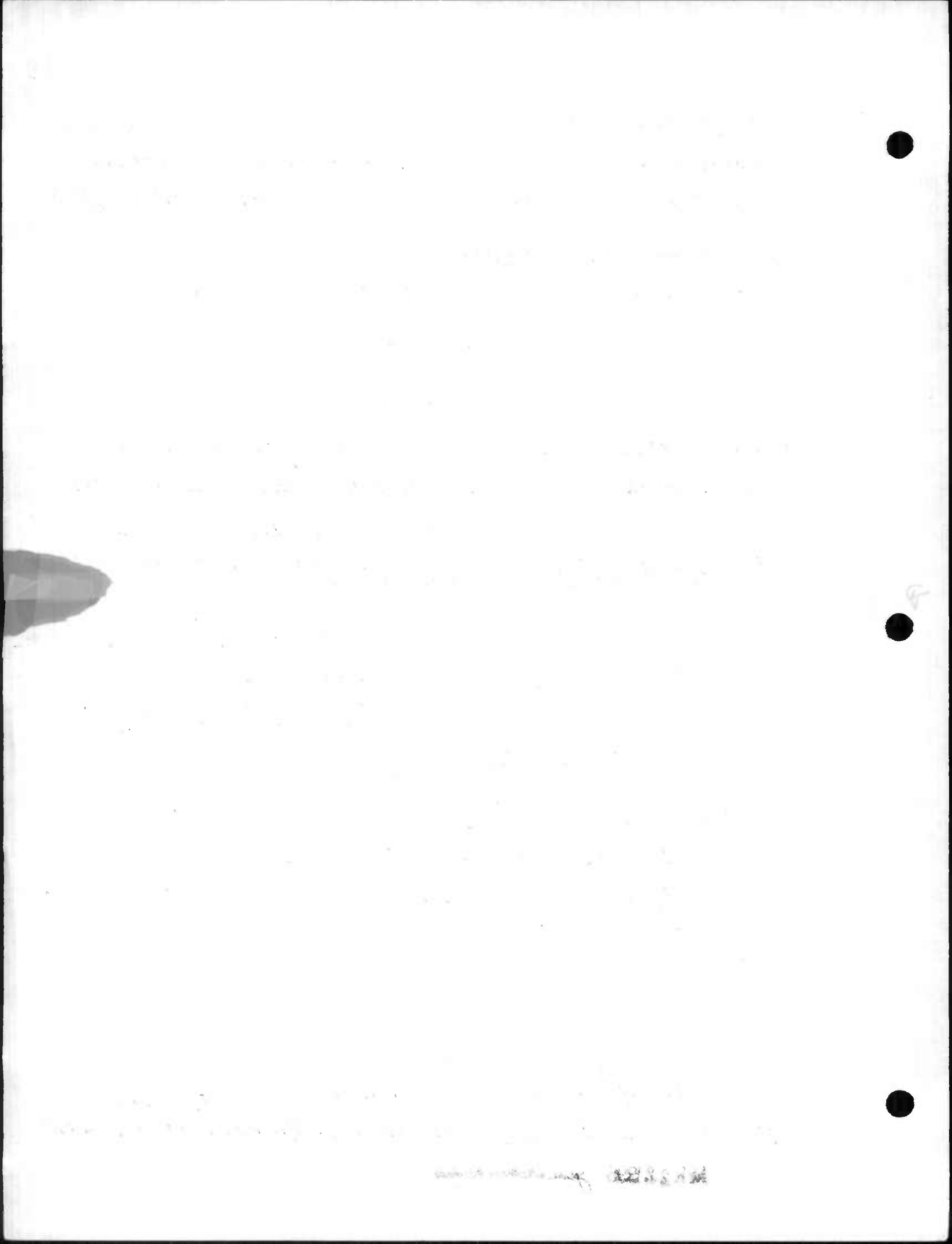
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13220

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elwood Richard SHOWE

2. Date of Death

April 22 1996

3. Time of Death

1335

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214 14 6689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 24, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12543 Bradbury Avenue

10f. Zip Code

21783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self-employed optician

16b. Kind of Business/Industry

optometrist

17. Father's Name (First, Middle, Last)

Ivan Leslie Showe

18. Mother's Name (First, Middle, Maiden Surname)

Anna Martha Dotter

19a. Informant's Name/Relationship (Type, Print)

Martha Bachtell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12543 Bradbury Ave., Smithsburg, Md. 21783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

4-23-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 11133

29d. Date signed (Month, Day, Year)

Apr 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles C. Spencer 1198 Kenly Ave Hagerstown MD 21740

31. Date filed (Month, Day, Year)

APR 23 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very important document, as it contains the President's message to Congress for the first time since the beginning of the Civil War. The letter is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a letter from the Secretary of the War Department to the Secretary of the Navy, dated January 10, 1862. It is a very important document, as it contains the Secretary's report on the progress of the war. The letter is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a letter from the Secretary of the War Department to the Secretary of the Navy, dated January 10, 1862. It is a very important document, as it contains the Secretary's report on the progress of the war. The letter is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13221

Guy Hance Slagle

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Guy H. SLAGLE				2. Date of Death Month Day Year APRIL 23, 1996		3. Time of Death 6:35 AM	
4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington	
5. Social Security Number 176-01-8023		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 10, 1897	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 440 West Washington Street		10f. Zip Code 21740		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner		16b. Kind of Business/Industry general grocery			
17. Father's Name (First, Middle, Last) Samuel Guy Slagle				18. Mother's Name (First, Middle, Maiden Surname) Minnie Harner			
19a. Informant's Name/Relationship (Type, Print) Peggy Hess				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 N. Artizan Street Williamsport, Maryland 21795			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hope Cemetery		20c. Date 4/25/96		20d. Location - City or Town, State Woodsboro, Maryland	
21. Signature of Funeral Service Licensee Gerald N. Minnich				22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Infarct Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death 1 WEEK							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier J. E. Howe, MD				29c. License number D 33700		29d. Date signed (Month, Day, Year) APRIL 23, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713							
31. Date filed (Month, Day, Year) APR 23 1996				32. Registrar's Signature John Anderson			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 23 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerState  
Registrar

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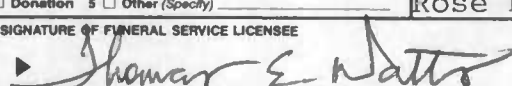
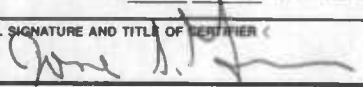
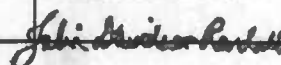
Amend # 7 Wash. CO. Health Dept. LB 04-23-96

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

96 13222  
04-23-96

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William Ferdinand Stewart</b>				2. DATE OF DEATH MONTH <b>April</b> , DAY <b>19</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>6:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-09-9663</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH MONTH <b>April</b> , DAY <b>10</b> , YEAR <b>12</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		8c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>112 West Bethel Street</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanical Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Viola Mae Stewart</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Carole Johnson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>958 Noland Drive Hagerstown, MD 21740</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery 4/24/96</b>		20c. LOCATION — City or Town, State <b>Hagerstown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Watsons Funeral Home 24 WBethel St. Hagerstown, MD 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Hepatic Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>2 wks</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>End stage Cirrhosis of Liver</b> DUE TO (OR AS A CONSEQUENCE OF):				2 years	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D21944</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jane S. Gribben 1475 Forest Ave 300 W 9th Frederick MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 23 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911

1911

96 13223

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDREW Earhart SEARS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>12:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-14-2685</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 8, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>VA MARYLAND HEALTH CARE SYSTEM</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PERRY POINT</b>	
9c. COUNTY OF DEATH <b>CECIL</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Odenton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Lamonte Avenue</b>	
10f. ZIP CODE <b>21113</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>				16b. KING OF BUSINESS/INDUSTRY <b>Union #101</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel J. Sears</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Weber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gail Riley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2243 Bachman Valley Rd, Manchester, MD 21102</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park 4/24</b>			
20c. LOCATION — City or Town, State <b>Baltimore, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>			
22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home 934 S Main St, Hampstead, MD 21074</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>DEMENTIA</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>CEREBRAL VASCULAR ACCIDENT</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> d.  Approximate Interval Between Onset and Death <b>5 days</b> <b>7 yrs. 8 mo.</b> <b>7 yrs. 4 mo.</b> <b>7 yrs.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) <b>M</b>				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amelia P. [Signature]</i>			
29c. LICENSE NUMBER <b>ME 0066318</b>				29d. DATE SIGNED (Month, Day, Year) <b>04/22/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>OMAR PEREZ, M.D. VAMC PERRY POINT PERRY POINT, MD 21902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 23 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13224

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willis Booker		2. Date of Death Month Day Year April 16, 1996		3. Time of Death 5:50 PM
	4a. Facility Name (If not institution, give street and number) Memorial Hospital @ Easton		4b. City, Town, or Location of Death Easton		4c. County of Death Talbot
Funeral Director	5. Social Security Number 212-20-6225	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 16, 1905		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 25 - S. Aurora Street		10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secondary Teacher		16b. Kind of Business/Industry County High School
	17. Father's Name (First, Middle, Last) William Scott		18. Mother's Name (First, Middle, Maiden Surname) Rachel Lisby		
	19a. Informant's Name/Relationship (Type, Print) Willis B. Scott Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29756 Piney Hill Road Trappe, Maryland 21673		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Paradise Cemetery		20c. Location - City or Town, State 4/20/96 Trappe, Maryland
	21. Signature of Funeral Service Licensee Janelle C. Henry		22. Name and Address of Facility HENRY FUNERAL HOME 510 Washington St. Cambridge, Maryland 21613		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GASTRIC CARCINOMA WITH METASTASIS Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. CONGESTIVE HEART FAILURE Due to (or as a consequence of): d. ANEMIA		Approximate Interval Between Onset and Death MONTHS WEEKS WEEKS WEEKS		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		
			28b. Time of Injury M		
			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Daniel E. Makas, DO		
	29c. License number H 48241		29d. Date signed (Month, Day, Year) 4/16/96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel E. Makas, DO 508 Idlewild Ave. Easton, Maryland 21601				
	31. Date filed (Month, Day, Year) APR 19 1996				
32. Registrar's Signature Julia Anderson-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ITEMS: 23 PART I, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene  
 PER MEO FILM G-735 5/9/96 t.t

96 13225

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES LINCOLN SCHULTZ JR.</b>				2. Date of Death Month Day Year <b>APRIL 02, 1996</b>		3. Time of Death <b>1900PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>EAST BALTIMORE STREET IN FIELD</b>				4b. City, Town, or Location of Death <b>FUNKSTOWN</b>		4c. County of Death <b>WASHINGTON</b>		
Funeral Director	5. Social Security Number <b>217-42-8893</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1948</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>								
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Funkstown</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>43 Frederick Road</b>				10f. Zip Code <b>21734</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 Years</b> College (14 or 5+) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>County Government</b>		
17. Father's Name (First, Middle, Last) <b>James Lincoln Schultz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen Register</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Ruth A. Sklencar/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>328 Lanafield Circle, Boonsboro, MD 21713</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory 4/26/96</b>		Data <b>Smithsburg, Maryland</b>		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>Douglas A. Fiery</i>				22. Name and Address of Facility <b>Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North, Hagerstown, MD 21742</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ENVIRONMENTAL HYPOTHERMIA</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Spontaneous investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>FOUND 4/2/96</b>		28b. Time of Injury <b>6:00 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>FOUND IN A FIELD DURING COLD WEATHER</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND EAST BALTIMORE STREET IN FIELD</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>FUNKSTOWN, WASHINGTON CO., MD.</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Monique D. Hall</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 03, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYSAM D. KOSOWSKI 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>APR 2 9 1996</b>				32. Registrar's Signature <i>John D. ...</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13226

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES NEWTON SHOWELL

2. Date of Death

Month Day Year  
APRIL 11, 1996

3. Time of Death

5:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

084-22-2871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth

Month Day Year  
AUG 15, 1915

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Frankford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

R.D. 3 BOX 95 J

10f. Zip Code

19945

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Home Maintenance

17. Father's Name (First, Middle, Last)

Charles Sturgis

18. Mother's Name (First, Middle, Maiden Surname)

Allie (Maiden Name Unknown)

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Newton / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.D. 3 BOX 95 J, Frankford, Delaware 19945

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Curtis Church Cemetery

Date

4/15/96 Bishopville, Maryland

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

Watson Funeral Home, Inc.

211 Washington St., Millsboro, Delaware 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction  
Due to (or as a consequence of):b. diabetes  
Due to (or as a consequence of):c. Hypertension  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

04-11-96

28b. Time of Injury

0300 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

found dead @ home, resuscitated

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Richard T. Watson MD

29c. License number

D 44108

29d. Date signed (Month, Day, Year)

04-11-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. R. / Atlantic General Hospital Berlin, MD

31. Date filed (Month, Day, Year)

APR 17 1996

32. Registrar's Signature

John A. Russell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13227

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eulalie Smack</b>				2. Date of Death Month <b>April</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>11:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>219-14-4006</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 19, 1900</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Fruitland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>206 S. Division Street</b>		10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>None</b>		17. Father's Name (First, Middle, Last) <b>Henry Anderson</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Pollitt</b>		19a. Informant's Name/Relationship (Type, Print) <b>Maurice Anderson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23124 Nanticoke Rd. Quantico Md. 21856</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Calvary Church Cem.</b>		20c. Date <b>4/3</b>		20d. Location - City or Town, State <b>Fruitland, Md.</b>		21. Signature of Funeral Service Licensee <b>Bladys B. Stewart</b>	
	22. Name and Address of Facility <b>Stewart Funeral Home</b>		22b. Address <b>821 West Rd. Salisbury, Md. 21801</b>		23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Urosepsis</b> Due to (or as a consequence of): <b>Advanced Age AND Dementia</b>		Approximate Interval Between Onset and Death <b>3 Days</b>	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D-39813</b>		29d. Date signed (Month, Day, Year) <b>4/8/96</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>		31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar	



96 13228

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>OLIN FRED SHOCKLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1996</b>		3. TIME OF DEATH <b>4:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-18-6544</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 15, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>108 Shamrock Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>108 Shamrock Dr.</b>	
10f. ZIP CODE <b>21804</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II Army</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Police Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Law Enforcement</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William G. Shockley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Hammond</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Wilma Shockley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Shamrock Dr. Salisbury, Md. 21804</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Md. Veterans Cem E.S. 4/8</b>		20c. LOCATION — City or Town, State <b>Hurlock, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald E. Bunch</i>				22. NAME AND ADDRESS OF FACILITY <b>Bounds Funeral Home, Salisbury, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>1 month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. A. Shockley, M.D.</i>				29c. LICENSE NUMBER <b>1225674</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. A. Shockley, M.D. 100 Down St., Salisbury, Md 21801</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13229

Amended Item #9c WCHD 04/02/96 PJS

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph John Samuels JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar. 28, 1996</b>		3. TIME OF DEATH <b>9:47A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>222-65-4572</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 6, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Waterview Healthcare Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico Maryland</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Crisfield</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Apt. 16, Somerset Village Apts.</b>				10f. ZIP CODE <b>21817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		18b. KIND OF BUSINESS/INDUSTRY <b>None</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph John Samuels SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Samuels</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ira Sturgis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25158 Nanticoke Rd. Quantico, Md. 21856</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Unionville Cemetery</b>		DATE <b>4/2</b>		20c. LOCATION — City or Town, State <b>Pocomoke, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys B. Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic gastric cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Serumoma</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Wm. Robins</b>				29c. LICENSE NUMBER <b>029349</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/28/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Wm. Robins Salisbury Md</b>							
31. DATE FILED (Month, Day, Year) <b>APR 01 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Shivers Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13230

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin F Smith, Sr

2. Date of Death

Month

Day

Year

4 18 96

3. Time of Death

1643

4a. Facility Name (If not institution, give street and number)

Maryland Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

218-30-3997

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/21/32

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

576 Marlboro Road

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Henry

Smith

18. Mother's Name (First, Middle, Maiden Surname)

Alice

Evans

19a. Informant's Name/Relationship (Type, Print)

Melvin E. Smith, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

576 Marlboro Rd. Lothian, MD 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Moses Cemetery

Date

4/24/96

20c. Location - City or Town, State

Lothian, MD

21. Signature of Funeral Service Licensee

Gladys A. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Necrotizing Fasciitis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

26 days

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth M. Hurwitz

29c. License number

ME 0063644

29d. Date signed (Month, Day, Year)

4/18/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kenneth M. Hurwitz

Maryland Shock Trauma, Baltimore, MD

31. Date filed (Month, Day, Year)

APR 22 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

107

The first part of the report is devoted to a description of the  
the results of the experiments conducted in the laboratory of the  
the results of the experiments conducted in the laboratory of the

The second part of the report is devoted to a description of the  
the results of the experiments conducted in the laboratory of the  
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The third part of the report is devoted to a description of the  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13231

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GARRIE LEWIS SHOPE, SR				2. Date of Death Month Day Year April 21 1996		3. Time of Death 5:25 am		
	4a. Facility Name (If not institution, give street and number) 1285 Chesapeake Beach Road, West				4b. City, Town, or Location of Death Owings		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 208 10 0219	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 5, 1912		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Owings		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1285 Chesapeake Beach Road, West				10f. Zip Code 20736		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry construction		
	17. Father's Name (First, Middle, Last) William C. Shope				18. Mother's Name (First, Middle, Maiden Surname) Millie Anna McCracken				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Iva N. Shope / spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 4/25/96		20c. Location - City or Town, State Cheltenham, MD		
	21. Signature of Funeral Service Licensee William R. Shope				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, Maryland				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Cancer								
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9 years								
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				23d. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				
	23e. Part 5. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				23f. Part 6. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				
	23g. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				23h. Part 8. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				
	23i. Part 9. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				23j. Part 10. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				
	23k. Part 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				23l. Part 12. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Harry R. Shope		29c. License number D20352		29d. Date signed (Month, Day, Year) 4/22/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HARRY R. SHOPE, MD 8926 WOODYARD Rd. CLINTON, MD									
31. Date filed (Month, Day, Year) APR 23 1996		32. Registrar's Signature Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



VOID

CERTIFICATE 00

96-13232

SEE

CERTIFICATE 00

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

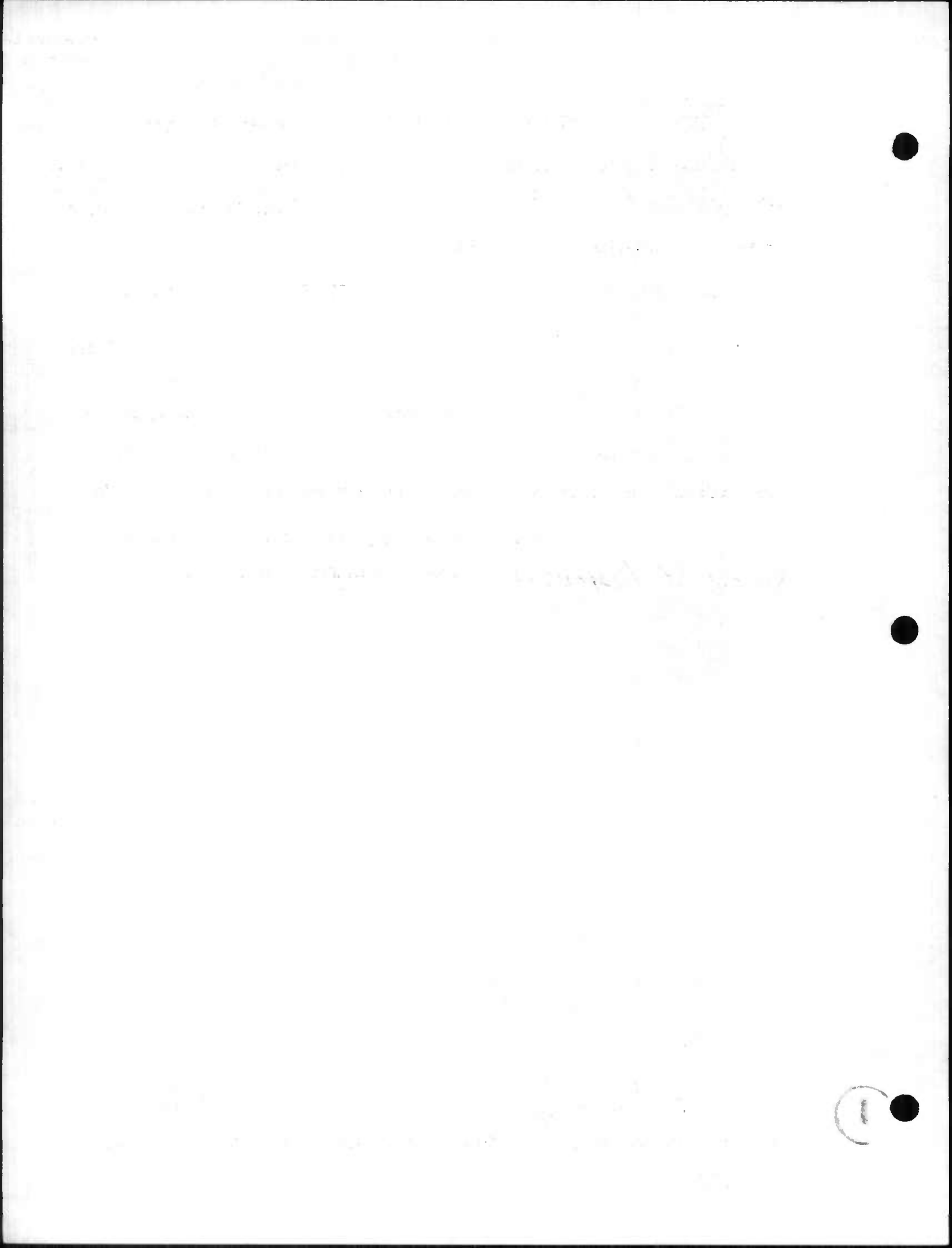
Reg. No.

96 13233

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN WILLIAM STOCKMAN				2. Date of Death Month Day Year April 16, 1996		3. Time of Death 7:55 p.m.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 217-10-0369		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 12, 1905		
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Middletown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4432 Valley View Road		10f. Zip Code 21769		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction					
17. Father's Name (First, Middle, Last) Harvey A. Stockman				18. Mother's Name (First, Middle, Maiden Surname) Nettie Bessie Greenwalt					
19a. Informant's Name/Relationship (Type, Print) Mrs. Wilhelmina S. Stockman				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4432 Valley View Rd., Middletown, Md. 21769					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date April 19, 1996		20c. Location - City or Town, State Frederick, Md.			
21. Signature of Funeral Service Licensee <i>Richard C.C. Basford</i> MO0021		22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701							
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  e. <i>Congestive Heart Failure</i> Due to (or as a consequence of):  b. <i>Pneumonia</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 24 hrs. 4 days							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Austin Pearre, Jr.</i>		29c. License number D09689		29d. Date signed (Month, Day, Year) 4/17/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin A. Pearre, Jr., M.D., 300 West Ninth Street, Frederick, Md. 21701									
31. Date filed (Month, Day, Year) APR 18 1996		32. Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 13234

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bertha Marie SHAFER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 12, 1996</b>		3. TIME OF DEATH <b>12:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>505-07-8360</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 30, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Nebraska</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Frederick</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>624 Biggs Avenue</b>	
10f. ZIP CODE <b>21702</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>Aug. 1943 - Jan. 1946</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Hostess - Cashier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hotel - Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown Krispel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard Dennis Shafer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6913 Greenvale Court, Frederick, Md. 21702</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Reformed Cemetery April 16, 1996</b>		20c. LOCATION — City or Town, State <b>Middletown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C.P. Basford</i> M00021				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <i>Acute AF Bleed</i></b>							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b><i>(M) Acute peritonitis due to recent stroke</i></b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Phillip Shapiro</i>				29c. LICENSE NUMBER <b>D 07186</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 12, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 27) (Type, Print) <b>Dr. Phillip Shapiro MD 814 Toll House Avenue, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 15 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. Health and Mental Hygiene prior to burial, cremation, or removal.

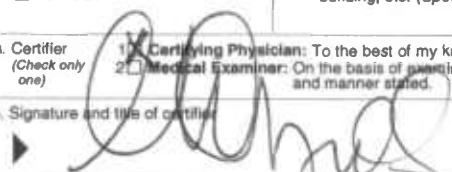
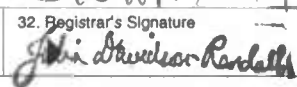
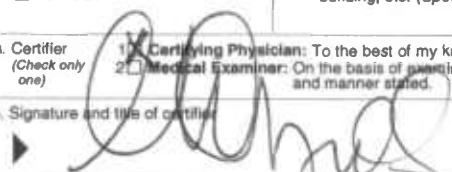
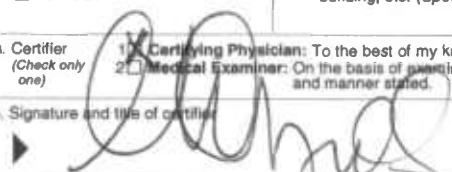
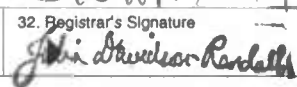
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13235

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>George William Scheetz</b>						2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>2315</b>																																																																															
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>						4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>																																																																															
<b>Funeral Director</b>	5. Social Security Number <b>218-07-2344</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.																																																																															
	6. Date of Birth (Month, Day, Year) <b>Oct. 26, 1919</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Va.</b>		10b. County <b>Moneta</b>		10c. City, Town or Location <b>Moneta</b>																																																																															
Usual Residence of Decedent																																																																																								
10a. State <b>Va.</b>			10b. County <b>Moneta</b>			10c. City, Town or Location <b>Moneta</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																																																															
10e. Street and Number <b>Rt. 2 Box 372</b>						10f. Zip Code <b>24121</b>		10g. Citizen of What Country? <b>U.S.A.</b>																																																																																
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W. W. II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																																																																															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>dispatcher</b>			16b. Kind of Business/Industry <b>state police</b>																																																																															
17. Father's Name (First, Middle, Last) <b>Harvey Scheetz</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Annie May Cannon</b>																																																																																		
19a. Informant's Name/Relationship (Type, Print) <b>Lorraine Adcock (Sister)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 Heather Ridge Dr., Frederick, Md. 21701</b>																																																																																		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Culpepper National Cemetery</b>			20c. Location - City or Town, State <b>4/17 Culpepper, Va.</b>																																																																															
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>																																																																																		
23a. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																																								
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%; text-align: center;"><b>Ventricular Fibrillation</b></td> <td style="width:20%; text-align: center;"><b>1 hr</b></td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 4em;">{</td> <td style="text-align: center;">a. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">b. <b>Acute Respiratory Failure</b></td> <td style="text-align: center;"><b>36 hrs</b></td> </tr> <tr> <td style="text-align: center;">c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d. <b>Chronic Obstructive Pulmonary Dx</b></td> <td></td> </tr> <tr> <td colspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)	<b>Ventricular Fibrillation</b>	<b>1 hr</b>	{	a. Due to (or as a consequence of):		b. <b>Acute Respiratory Failure</b>	<b>36 hrs</b>	c. Due to (or as a consequence of):		d. <b>Chronic Obstructive Pulmonary Dx</b>		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last																																																																	
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Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13236

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN MARIE STOTLER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1996</b>		3. TIME OF DEATH <b>9:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-12-1045</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 28, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1421 Taney Avenue</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager Cafeteria</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Forsyth</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Mary Trovinger</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donna D. Wiles</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5543 Buffalo Road, Mt. Airy, Maryland 21771</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens 4/13</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>3 wks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>POLYMYALGIA RHEUMATICA / DIABETES MELLITUS</b> <b>KLEBSIELLA PNEUMONIA</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Andrew O. Donelson MD</b>				29c. LICENSE NUMBER <b>021936</b>		29d. DATE SIGNED (Month, Day, Year) <b>4.11.96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Andrew O. Donelson, MD 915 Toll House Avenue, Frederick, MD 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Changed line 189 J.D. FCHD

96 13237

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Edward STEIN Sr</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 9, 1996</b>		3. TIME OF DEATH <b>5:30am</b>	
4. SOCIAL SECURITY NUMBER <b>578-07-8097</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 16, 1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Citizens Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Frederick</b>				10c. CITY, TOWN OR LOCATION <b>Frederick</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1900 Rosemont Avenue</b>			
10f. ZIP CODE <b>21702</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retail Sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Tailoring Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jacob M STEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leona Rebecca BERNSTEIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Arthur D. Stein</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11710 Lytle Street, Wheaton, Maryland 20902</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory Apr 9, 1996 Smtihsburg, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith Lynn Robinson</i> <b>MO0706</b>		22. NAME AND ADDRESS OF FACILITY <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, Maryland</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 wk</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Kaufmann</i>				29c. LICENSE NUMBER <b>D13971</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 9, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CRUISE OF DEATH (ITEM 27) (Type, Print) <b>Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 09 1996</b>		32. REGISTRAR'S SIGNATURE <i>Julia Annick Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

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96 13238

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANN DELLA STATEN</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>16</b> YEAR <b>96</b>		3. TIME OF DEATH <b>825 A M</b>	
4. SOCIAL SECURITY NUMBER <b>238-38-3855</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 28-1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>400 TRINITY DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>400 TRINITY DRIVE</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>US</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 YRS</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FARM LABOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AGRICULTURE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LESLIE E BISHOP</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 TEXAS RD BIVANUE 21814 MD.</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY 4/16/96</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>C. G. FENNER</b>				22. NAME AND ADDRESS OF FACILITY <b>MESSICK FUNERAL HOME PO BOX 61 BIVANUE, MD 21814</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>8 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. E. MARTIN M.D.</b>				29c. LICENSE NUMBER <b>030690</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/16/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES E. MARTIN M.D. 145 E CARROLL ST. SALISBURY, MD. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>APR 16 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13239

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Kern Torovsky				2. Date of Death Month Day Year April 13 1996		3. Time of Death 9:30	
	4a. Facility Name (If not institution, give street and number) 947 Shadewater Way				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 577-16-5395		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) March 28, 1916	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 947 Shadewater Way		10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) John Augustus Kern	
	18. Mother's Name (First, Middle, Maiden Surname) Margaret Barger		19a. Informant's Name/Relationship (Type, Print) Richard H. Torovsky, Jr./Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 Solomon Seal Drive Springfield, Virginia 22152		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. COPD Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 5 hrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast CA		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D33044		29d. Date signed (Month, Day, Year) 4/12/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 RICHARD BERNSTEIN 600 RIDGEWAY AVE #121 ANNAPOLIS		31. Date filed (Month, Day, Year) APR 22 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 13240

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH LUCILLE TAYLOR				2. DATE OF DEATH MONTH DAY YEAR April 11, 1996		3. TIME OF DEATH 7:40 A M	
4. SOCIAL SECURITY NUMBER 578-40-5053		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 14, 1931	
8. BIRTHPLACE (State or Foreign Country) Connecticut				9a. FACILITY NAME (If not institution, give street and number) 108 120th. St., C.O.V. #72		9b. CITY, TOWN OR LOCATION OF DEATH Ocean City	
9c. COUNTY OF DEATH Worcester				10a. STATE Maryland		10b. COUNTY Worcester	
10c. CITY, TOWN OR LOCATION Ocean City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 108 120th. St., C.O.V. #72				10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Management		15b. KIND OF BUSINESS/INDUSTRY Real Estate			
17. FATHER'S NAME (First, Middle, Last) John Eaton Waldo				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaretha Zipula Propson			
19a. INFORMANT'S NAME (Type/Print) Richard B. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 120th St., C.O.V. #72, Ocean City, MD 21842			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 4/12		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Wompa</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. Tobacco abuse DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.A. Cockley</i>				29c. LICENSE NUMBER 025679		29d. DATE SIGNED (Month, Day, Year) 4/12/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.A. Cockley, MD 100 Power St., Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) APR 12 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Parrott</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13241

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES R. TRUITT</b>				2. Date of Death Month <b>APRIL</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>8:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>221-01-0342</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 24, 1908</b>	
	9. Birthplace (State or Foreign Country) <b>WICOMICO COUNTY</b>		10a. State <b>MD.</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>PITTSVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>RAILROAD AVENUE</b>		10f. Zip Code <b>21850</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CASHIER</b>		16b. Kind of Business/Industry <b>BANK</b>			
	17. Father's Name (First, Middle, Last) <b>ANANIAS B. TRUITT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY EVANS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>JOANNE HASTINGS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1515 LILAC DRIVE, SALISBURY, MD. 21801</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVERGREEN CEMETERY</b>		Date <b>4/11</b>		20c. Location - City or Town, State <b>BERLIN, MD.</b>	
	21. Signature of Funeral Service Licensee <i>Gerald C. Bounds</i>				22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of): <b>b. Dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic Anemia, Etiology unknown with macrocytosis and iron deficiency</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Michael Atkins MD</i>		29c. License number <b>D-39813</b>	
	29d. Date signed (Month, Day, Year) <b>4/8/96</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ATKINS, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>							
	31. Date filed (Month, Day, Year) <b>APR 09 1996</b>				32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13242

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AURELIUS JAMES TAYLOR SR</b>				2. Date of Death Month <b>MARCH 29</b> Day <b>1996</b> Year		3. Time of Death <b>1:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER, GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>218-20-5826</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 27, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Delmar</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>8604 Middle Sex Drive</b>		10f. Zip Code <b>21875</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/operator</b>		16b. Kind of Business/Industry <b>Grocery</b>			
	17. Father's Name (First, Middle, Last) <b>William S Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Townsend</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia J. Houck</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8604 Middle Sex Dr., Delmar, MD 21875</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>		20c. Date <b>4/2/96</b>		20d. Location - City or Town, State <b>Hebron, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>			
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <i>Acute pulmonary edema</i> Due to (or as a consequence of):</p> <p>b. <i>Multiple CVA's</i> Due to (or as a consequence of):</p> <p>c. <i>congestion heart failure</i> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown							
	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No							
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No								
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No								
26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)								
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D-29349</b>		29d. Date signed (Month, Day, Year) <b>5/29/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD.</b>								
31. Date filed (Month, Day, Year) <b>APR 01 1996</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13243

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA MAE TOPPER				2. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1996		3. TIME OF DEATH 9:55 P. M	
4. SOCIAL SECURITY NUMBER 170-24-2081		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	7. DATE OF BIRTH (Month, Day, Year) MAY 18, 1917	8. BIRTHPLACE (State or Foreign Country) EMMITSBURG, MD		
9a. FACILITY NAME (If not institution, give street and number) 28 FEDERAL AVE.				9b. CITY, TOWN OR LOCATION OF DEATH EMMITSBURG		9c. COUNTY OF DEATH FREDERICK	
10a. STATE MARYLAND				10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION EMMITSBURG	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 28 FEDERAL AVE.				10f. ZIP CODE 21727		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY CHILD CARE SETON CENTER			
17. FATHER'S NAME (First, Middle, Last) JAMES ALAN GELWICKS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SPALDING			
19a. INFORMANT'S NAME (Type/Print) LEO B. TOPPER, SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 FEDERAL AVE., EMMITSBURG, MD. 21727			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORIUM		20c. LOCATION — City or Town, State SMITHSBURG, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Skiles</i>				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Carcinoma of Breast with</i>					Approximate Interval Between Onset and Death 18 mo
		b. <i>Multiple Pulmonary and</i>					12 mo
		c. <i>Bony Metastases</i>					12 mo
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan Carroll MD</i>				29c. LICENSE NUMBER D18705		29d. DATE SIGNED (Month, Day, Year) APRIL 14, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) APR 18 1996				32. REGISTRAR'S SIGNATURE <i>John Stuckler-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13244

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALBERTHA THOMPSON</b>				2. Date of Death Month Day Year <b>APRIL 10, 1996</b>				3. Time of Death <b>1201PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>				4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>219-07-2779</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>June 11, 1904</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>	
Usual Residence of Decedent										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <b>1200 West Liberty Road</b>				10f. Zip Code <b>21784</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own home.</b>		
17. Father's Name (First, Middle, Last) <b>George Mayhew</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Mobley</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edgar L. Thompson, Jr. - Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12201 Piedmont Road, Clarksburg, Maryland 20871</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		Date <b>4/13/96</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>						22. Name and Address of Facility <b>Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. <b>MYOCARDIAL INFARCTION</b>										
Due to (or as a consequence of):										
b. <b>ATRIAL FIBRILLATION</b>										
Due to (or as a consequence of):										
c. <b>HYPERTHYROIDISM</b>										
Due to (or as a consequence of):										
d. <b>PERNICIOUS ANEMIA</b>										
Approximate Interval Between Onset and Death <b>1 DAY</b> <b>1 YEAR</b> <b>1 YEAR</b> <b>1 YEAR</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Van H. Schuchfeder MD</b>						29c. License number <b>D 28221</b>		29d. Date signed (Month, Day, Year) <b>APRIL 10, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAN H. SCHUCHFEDER, MD 200 MEMORIAL AVENUE WESTMINSTER MARYLAND</b>										
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>				32. Registrar's Signature <b>John A. ...</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


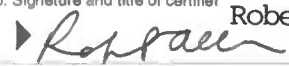
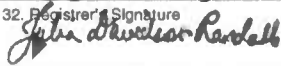
State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13245

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Ruth A. Taylor</b>				2. Date of Death Month <b>March</b> Day <b>30</b> Year <b>1996</b>				3. Time of Death <b>2:45 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center: Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury</b>				4c. County of Death <b>Wicomico</b>		
<b>Funeral Director</b>	5. Social Security Number <b>130-28-1775</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01 05 1938</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number <b>522 Winder St.</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>n/a</b>			16b. Kind of Business/Industry <b>n/a</b>			
	17. Father's Name (First, Middle, Last) <b>William Alston</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Velma Williams</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Charles D. Taylor</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>522 Winder St., Salisbury, MD 21801</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Macedonia BC Cemetery</b>		Date <b>4/3/96</b>		20c. Location - City or Town, State <b>Pocomoke City, MD</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Funeral Home Lewis N. Watson, 1618 West Rd. Salisbury, MD 21801</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>a. CONGESTIVE HEART FAILURE</b></p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 65%;"> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>										<p><b>10 DAYS</b></p>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
<p><b>VEGETATIVE STATE</b></p> <p><b>STATUS POST ARREST</b></p>										<p>24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  <b>Robert Baker Allen, MD</b>				29c. License number <b>D29168</b>		29d. Date signed (Month, Day, Year) <b>3/30/96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert B. Allen, Salisbury Nursing Home</b>											
31. Date filed (Month, Day, Year) <b>APR 02 1996</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 13246**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emilie Viktor</b>				2. Date of Death Month <b>April</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>06:12 a.m.</b>		
	4e. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>		
Funeral Director	5. Social Security Number <b>212-12-1887</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 1, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>Catonsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	10e. Street and Number <b>315 Ingleside Avenue</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>				
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Jan Vidimar/unknown</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>State rem.</b>		20c. Location - City or Town, State <b>State rem.</b>				
	21. Signature of Funeral Service Licensee <b>Joseph B. Van Sant</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial infarction</b> Due to (or as a consequence of): <b>b. Atherosclerosis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate interval between Onset and Death <b>2 hours</b> <b>10 years</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Transient Ischemic attacks</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dahna Batts Osborne MD</b>		29c. License number <b>D46325</b>		29d. Date signed (Month, Day, Year) <b>April 19, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1101 Shuppert Rd. #204 Lanham, MD. 20704</b>		31. Data filed (Month, Day, Year) <b>MAY 06 1996</b>						32. Registrar's Signature <b>J. Davidson-Randall</b>	

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13247

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES J. UEBERROTH</b>				2. Date of Death Month <b>4</b> Day <b>14</b> Year <b>96</b>		3. Time of Death <b>4:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>140 Georgetown Road</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>213-80-9236</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 15 1920</b>	9. Birthplace (State or Foreign Country) <b>England</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>140 Georgetown Road</b>				10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Francis E. Fox</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Constance M. Lindop</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Susan C. Ueberroth</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1754 Southern Hills Dr. Arnold, MD 21012</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory 4/17/96</b>			20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Approximate Interval Between Onset and Death <b>6 months</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier 			29c. License number <b>D 16354</b>			29d. Date signed (Month, Day, Year) <b>4/15/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Enser W. Coletti 900 Bestgate Rd Suite 300 Annapolis MD 21401</b>								
31. Date filed (Month, Day, Year) <b>APR 22 1996</b>			32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

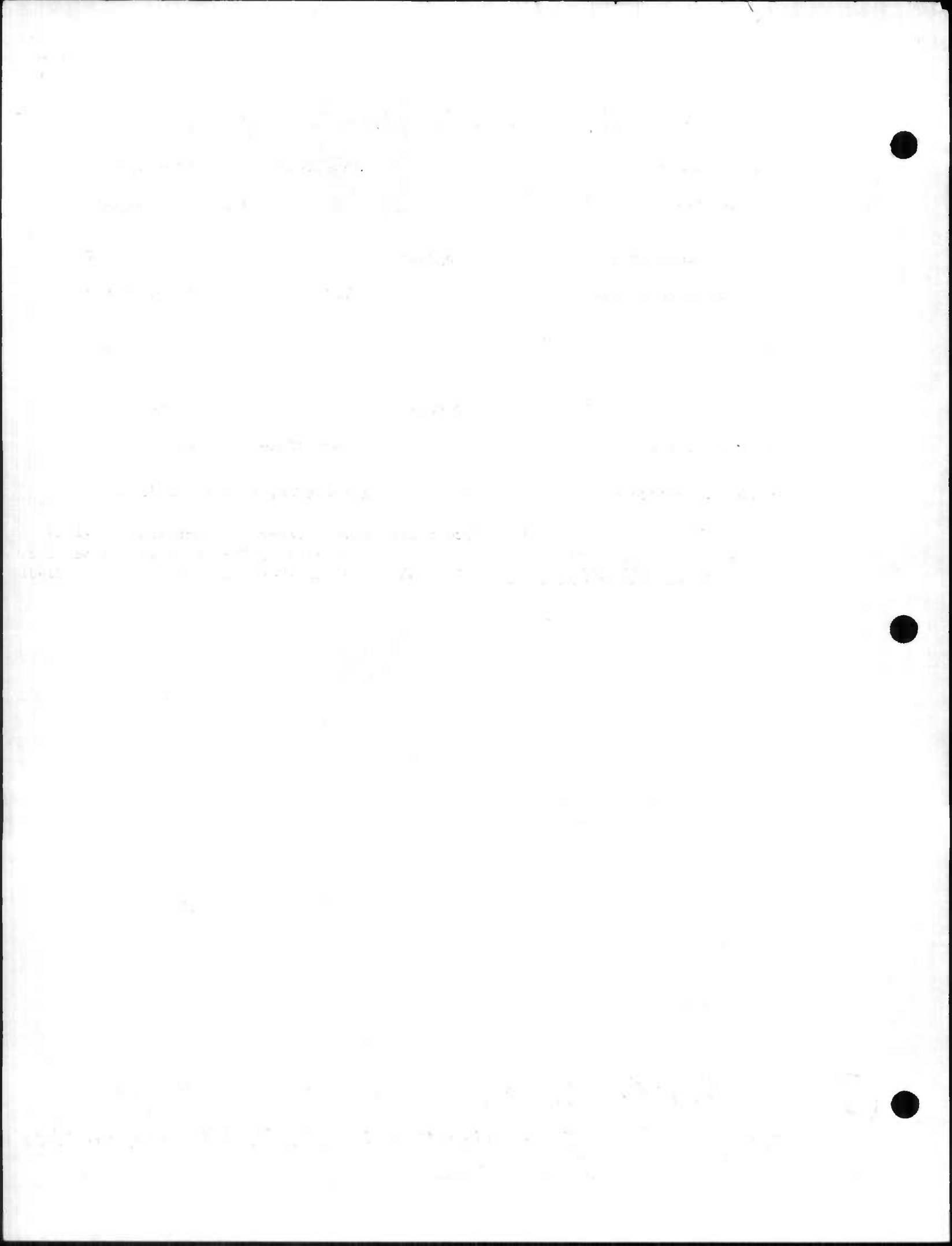
Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13248

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Mildred Jeanne West</b>					2. Date of Death Month <b>April</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>5:32 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>					4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>		
<b>Funeral Director</b>	5. Social Security Number <b>216-36-4670</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 3, 1940</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>894 Mulligan Lane</b>					10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12)      College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Stewart Matthew Wunder</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ruby Grace Ziegler</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Clark N. West III, husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>894 Mulligan Lane, Westminster, Md 21158</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Cemetery</b>			20c. Location - City or Town, State <b>Baltimore, MD</b>		20d. Date <b>4/20/96</b>		
21. Signature of Funeral Service Licensee <b>Kathleen Pitts - Switzer</b>					22. Name and Address of Facility <b>Pitts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>METASTATIC SMALL CELL LUNG CA</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <div style="border-left: 2px solid black; padding-left: 10px; margin-left: 10px;"> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>1 km</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Flavio Kruter MD</b>					29c. License number <b>D35398</b>		29d. Date signed (Month, Day, Year) <b>4/17/96</b>			
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) <b>FLAVIO KRUTER - 684 A ROCKE RD - WESTMINSTER MD 21157</b>										
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>										
32. Registrar's Signature <b>J. P. Switzer</b>										

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
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 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13249

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY B. WELLS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 15 1996</b>		3. TIME OF DEATH <b>1510</b> M	
4. SOCIAL SECURITY NUMBER <b>217-05-7881</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 28 1921</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1337 TYLER AVENUE</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>US</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>A.A. CO. BD. OF EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MATTHEW C. BROWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE BROWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOHN W. WELLS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7358 EDGEWOOD RD. ANNAPOLIS, MD. 21403</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS</b>		DATE <b>4/20/96</b>		20c. LOCATION — City or Town, State <b>ANNAPOLIS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Septicemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Gangrene of leg</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. extensive peripheral vascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death <b>weeks</b> <b>months</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End stage renal disease</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory A. Mitchell</i>				29c. LICENSE NUMBER <b>D14758</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-16-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gregory A. Mitchell 205 Ridge Ave Annapolis MD 21401</b>							
31. DATE FILED (Month, Day, Year) <b>APR 18 1996</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 13250

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIAN V. WILKERSON</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>12</b> YEAR <b>96</b>		3. TIME OF DEATH <b>0630 AM</b>	
4. SOCIAL SECURITY NUMBER <b>212-26-9749</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 4 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2 Cypress Road</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Rye</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nora Kendricks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Steven B. Wilkerson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 1 Box 237A Seaford, Delaware 19973</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Gardens 4/15/96 Annapolis, Maryland</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home 147 Duke Of Gloucester St. Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ACUTE CARDIO-PULMONARY FAILURE</b>					Approximate interval Between Onset and Death <b>SUDDEN</b>
		b. <b>COAD, SPOKE #</b>					<b>YEARS</b>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>CARDIOMYOPATHY with CHF #</b>					<b>YEARS</b>
		d. <b>NIDDM</b>					<b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIASTOLIC, HYPERLIPIDEMIA, HTN B/P</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Taylor</i>				29c. LICENSE NUMBER <b>0231F2</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S.D. KRIMMALS 700 BEECHMATE RD ANNAPOLIS, MD 21403</b>							
31. DATE FILED (Month, Day, Year) <b>APR 16 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13251

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Field Wilber				2. Date of Death Month: APR Day: 10 Year: 96				3. Time of Death 1140								
	4a. Facility Name (If not institution, give street and number) Ginger Cove Health Care Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel								
Funeral Director	5. Social Security Number 375-26-4731		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Nov 7 1909		9. Birthplace (State or Foreign Country) Michigan								
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	10e. Street and Number 2303 River Crescent Drive				10f. Zip Code 21401		10g. Citizen of What Country? United States										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 2				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home										
	17. Father's Name (First, Middle, Last) Scott Field				18. Mother's Name (First, Middle, Maiden Surname) Katherine Waterbury												
	19a. Informant's Name/Relationship (Type, Print) Joan W. Arnold / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Elmwood Road Annapolis, MD 21402												
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		Date 4/12/96		20c. Location - City or Town, State Brentwood, Maryland										
	21. Signature of Funeral Service Licensee Donald S. Lyon				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. asphyxia, repeated Due to (or as a consequence of): c. Brain stem infarction Due to (or as a consequence of): d. HASCVD  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Cause) Last  100 3 mos 4 mos year										Approximate Interval Between Onset and Death						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. glucose intolerance										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Michael J. Zepentian		29c. License number 021438		29d. Date signed (Month, Day, Year) Apr 10 96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILITARY J. LA PENA 600 RINGBAY AVE STE 100 ANNAPOLIS MD 21401																	
31. Date filed (Month, Day, Year) APR 16 1996										32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

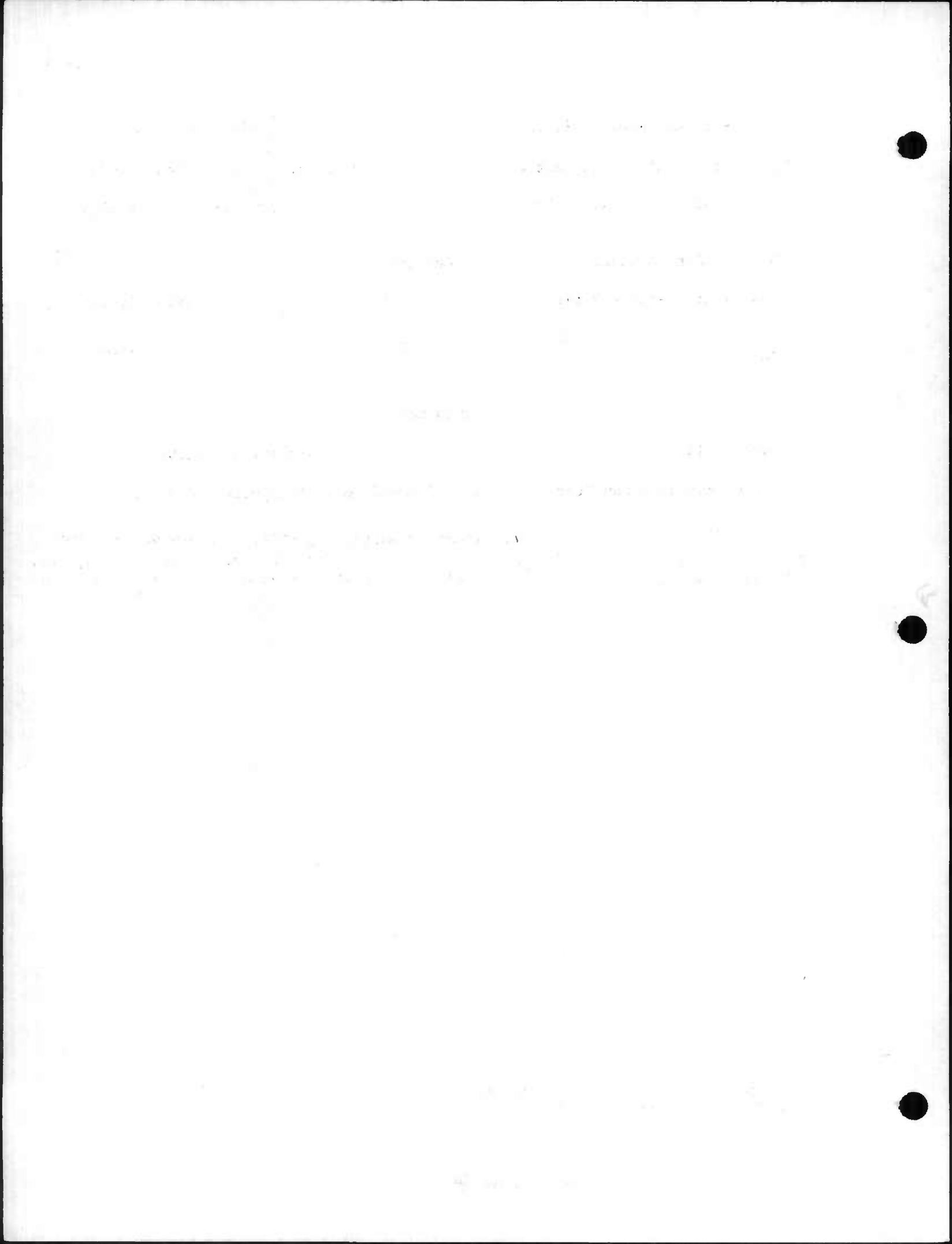
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended Line 4 JLD; FCHD as Per Funeral Director  
96 13252

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONALD LEROY WETZEL				2. DATE OF DEATH MONTH DAY YEAR February 1, 1996		3. TIME OF DEATH 2:30 A M					
4. SOCIAL SECURITY NUMBER 217-28-6241		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 23, 1931		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 420 Logan Street				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick, 420 Logan St.			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 420 Logan St.		10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant			16b. KIND OF BUSINESS/INDUSTRY U.S. Government						
17. FATHER'S NAME (First, Middle, Last) EZRA WETZEL				18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE ELIZABETH BAKER							
19a. INFORMANT'S NAME (Type/Print) JOCELYN S. WETZEL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Logan St./ Frederick, Maryland 21701							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Mount Olivet Cemetery		DATE 1/5		20c. LOCATION — City or Town, State Frederick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Petersen</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Bronchogenic Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 5 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Asthma, Positive PPD,</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward F. Fisher</i>						29c. LICENSE NUMBER D 36610		29d. DATE SIGNED (Month, Day, Year) February 1, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edward F. Fisher / 56 Thomas Johnson Dr./ Frederick, Md. 21702											
31. DATE FILED (Month, Day, Year) FEB 05 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

20

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR TO THE FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13253

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACK EDWARD Ware</b>		2. Date of Death Month <b>April</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>1536</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>721-14-7305</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>December 22, 1927</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>
	10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>228 Chestnut Way</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collage (1-4 or 5+) <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cable Splicer</b>		16b. Kind of Business/Industry <b>Phone Co.</b>		
	17. Father's Name (First, Middle, Last) <b>John Edward Ware</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Oakley Dell Cooper</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Ruby Marie Ware/Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>228 Chestnut Way, Salisbury, MD 21801</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute myocardial infarction</b>				Approximate Interval Between Onset and Death <b>Hours</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End-stage renal failure, COPD, peripheral vascular disease</b>				Approximate Interval Between Onset and Death <b>Years</b>
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Chronic atrial fibrillation</b>				Approximate Interval Between Onset and Death <b>Years</b>
	23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Chronic atrial fibrillation</b>				Approximate Interval Between Onset and Death <b>Years</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>[Signature]</i> <b>W.D.</b>		29c. License number <b>16735</b>		29d. Date signed (Month, Day, Year) <b>4/15/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TAN, CONSTANCE 547-D Riverside Dr, Salisbury, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>APR 17 1996</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13254

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS B. WILSON JR.				2. Date of Death Month Day Year APRIL 5, 1996		3. Time of Death 2106	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 216-20-5395	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 10, 1928		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location DAGSBORO		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 227 LONG LEAF ROAD- DOGWOOD ACRES				10f. Zip Code 19939		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAVERN OWNER		16b. Kind of Business/Industry ALCOHOL BEVERAGE SALES		
17. Father's Name (First, Middle, Last) THOMAS B. WILSON				18. Mother's Name (First, Middle, Maiden Surname) RHEA HETRICK				
19a. Informant's Name/Relationship (Type, Print) ELEANOR WILSON- wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 LONG LEAF RD., DOGWOOD ACRES, DAGSBORO, DE. 19939				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DELAWARE VA MEMORIAL CEM. 4/10/96		20c. Location - City or Town, State BEAR, DELAWARE				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MELSON FUNERAL SERVICES FRANKFORD, DELAWARE 19945				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. MYOCARDIAL INFARCTION</p> <p>b. HTN</p> <p>c. OBESITY</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>&lt; 10 mins</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D 28466		29d. Date signed (Month, Day, Year) 4/5/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Cragway, M.D. 9733 HEALTHWAY DR.								
31. Date filed (Month, Day, Year) APR 10 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

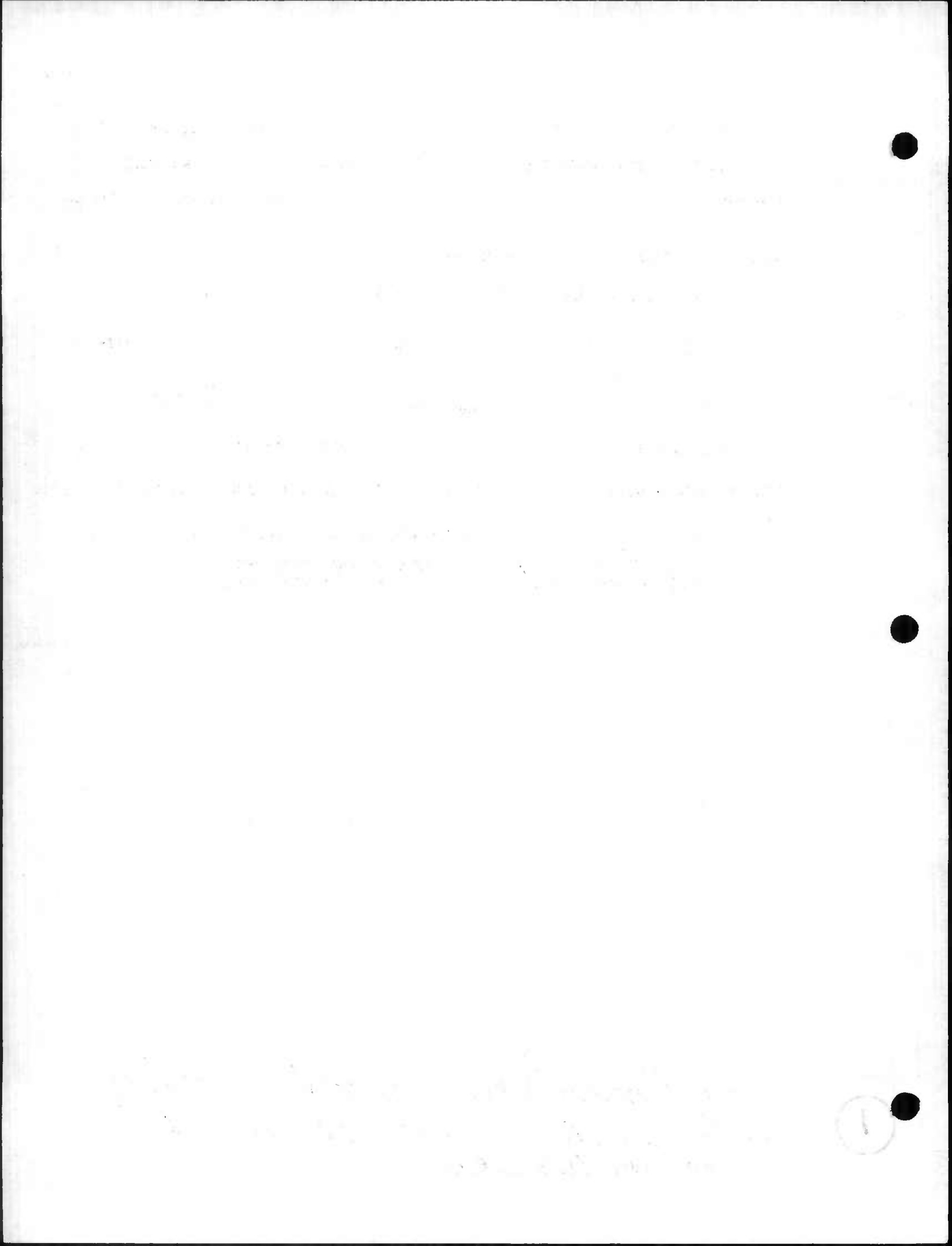
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13255

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Keith Wilkerson</b>				2. Date of Death Month Day Year <b>April 21, 1996</b>		3. Time of Death <b>4:55 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>FDG</b>	
Funeral Director	5. Social Security Number <b>577-76-1884</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>40</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>2-25-56</b>	9. Birthplace (State or Foreign Country) <b>WASHINGTON D.C.</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>PG</b>	10c. City, Town or Location <b>HYATTSVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6500 RIGGS ROAD</b>			10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>HYATTSVILLE, MD</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>PRIVATE</b>		
	17. Father's Name (First, Middle, Last) <b>THOMAS WILKERSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN CHANDLER WILKERSON</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARY JOHNSON - aunt</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3613 SILVER PARK DRIVE SUITLAND MD 20746</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HARMONY</b>		Date <b>5/1/96</b>		20c. Location - City or Town, State <b>LANDOVER MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>MORROW&amp;WOODFORD 1622 11ST N.W 20001</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>AIDS</b> Due to (or as a consequence of): <b>HEPATITIS</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CARDIO PULMONARY FAILURE</b> Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia</b>							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>(Maryland) D28906</b>		29d. Date signed (Month, Day, Year) <b>April 23, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert D. Skipworth MD, 585 Main St. Laurel, MD 20707</b>								
31. Data filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

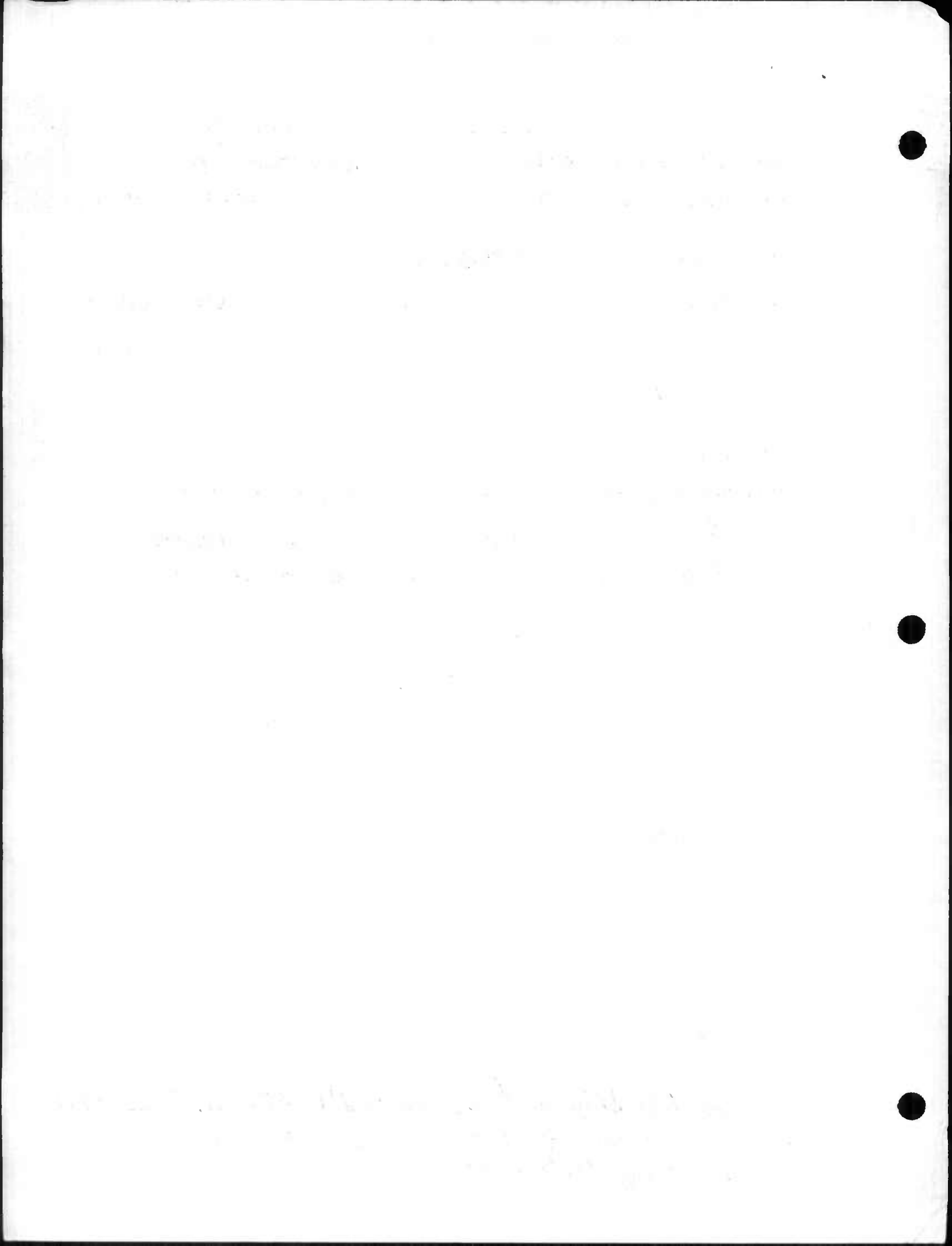
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

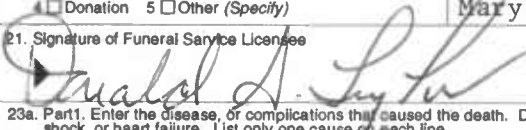
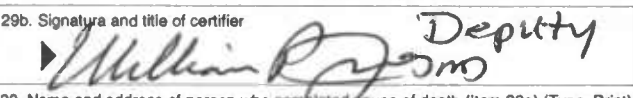
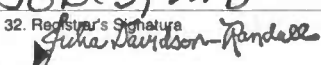


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State of Maryland / Department of Health and Mental Hygiene 96 13256

## Certificate of Death

Reg. No.

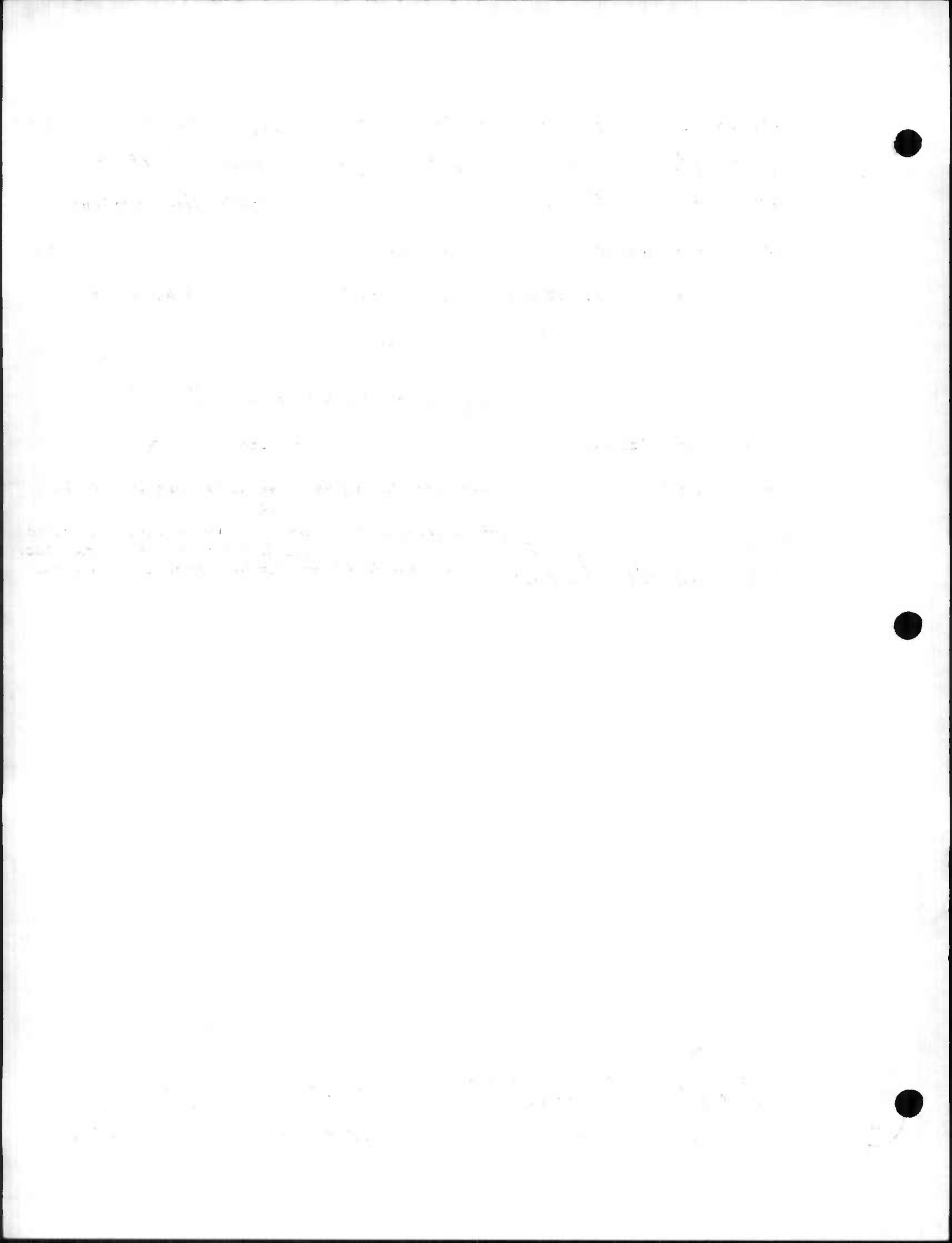
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES RAY WACHTER</b>				2. Date of Death Month Day Year <b>Apr 19 96</b>		3. Time of Death <b>0930</b>		
	4a. Facility Name (If not Institution, give street and number) <b>907 Ravens Head Hill</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>AA</b>		
Funeral Director	5. Social Security Number <b>216-12-9001</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 7 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>907 Ravens Head Hill, Sherwood Forest</b>				10f. Zip Code <b>21405</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Real Estate Agent &amp; Secretary</b>		16b. Kind of Business/Industry <b>Real Estate &amp; College</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Harry Edward Mitchell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Marie Wisig</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Denise M. Wolf</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5135 Cedarlea Drive West River, Maryland 20778</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		20c. Location - City or Town, State <b>Crownsville, Maryland</b>		20d. Date <b>4/22/96</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Head Injury</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>UNK.</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year) <b>4/19/96</b>		28b. Time of Injury <b>?</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Tripped + Fell</b>
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Annapolis, MD</b>						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier  <b>Deputy</b>		29c. License number <b>D06054</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>								
	31. Date filed (Month, Day, Year) <b>APR 22 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96-13257

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Evelyn Wills				2. Date of Death Month Day Year April 14, 1996		3. Time of Death 12:50 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-28-8955	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 22, 1933		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Knoxville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3712 South Mountain Road				10f. Zip Code 21758		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Collegia (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Earl BURDETTE				18. Mother's Name (First, Middle, Maiden Surname) Ollie KEYSER				
19a. Intendant's Name/Relationship (Type, Print) Bernard Earl Wills, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3712 South Mountain Road, Knoxville, Maryland 21758				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grossnickle Brethren Cemetery, April 17, 1996		Data Myersville, Md.		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Richard E. Graf M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. ATHEROSCLEROSIS Due to (or as a consequence of): c. HYPERLIPIDEMIA Due to (or as a consequence of): d. HYPERTENSION								Approximate Interval Between Onset and Death 48 hours Years Years Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE CHRONIC OBSTRUCTIVE PULMONARY DISEASE TOBACCO ABUSE x many years								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D47556		29d. Date signed (Month, Day, Year) 4/14/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. JOHNSON 56 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702								
31. Date filed (Month, Day, Year) APR 15 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13258

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rowena Loftus Wright			2. Date of Death Month Day Year April 16 1996		3. Time of Death 9 PM	
	4a. Facility Name (If not institution, give street and number) 87 Bay Drive			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-52-5649	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 15 1898	9. Birthplace (State or Foreign Country) Texas
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Annapolis			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 87 Bay Drive			10f. Zip Code 21403		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) John Loftus			18. Mother's Name (First, Middle, Maiden Summa) Sally Bozman			
	19a. Informant's Name/Relationship (Type, Print) Robert Maynard Wright, Sr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Bay Drive Annapolis, MD 21403			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery 4/23/ Arlington, Virginia		20c. Location - City or Town, State 1996		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke Of Gloucester St. Annapolis, MD 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Coronary Heart Failure</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
	28e. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier 			29c. License number D30718		29d. Date signed (Month, Day, Year) April 17, 1996	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John D. Jackson, M.D. 2003 Medical Pkwy. Suite 100 Annapolis, MD 21401 (410-573-1110)						
31. Date filed (Month, Day, Year) APR 22 1996 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13259

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MELVIN PRESTLEY

ALEXANDER Jr.

2. Date of Death

APRIL 25 1996

3. Time of Death

01:45 AM

4a. Facility Name (If not institution, give street and number)

800 BLK BEAUMONT AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-92-4646

6. Sex

M 2 F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 11, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes 2 No

10e. Street and Number

3729 1/2 BOARMAN AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Private Contractor

17. Father's Name (First, Middle, Last)

Melvin P. Alexander, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Grace Wilson

19a. Informant's Name/Relationship (Type, Print)

IRIS Alexander, sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3729 1/2 BOARMAN AVE Baltimore, Md 21215

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN Cemetery

20c. Location - City or Town, State

5-3-90

20d. Location - City or Town, State

WOODLAWN, Md

21. Signature of Funeral Service Licensee

Gray Harris

22. Name and Address of Facility

CHATMAN - Harris Funeral Home

5240 FORT STANLEY RD Baltimore, Md 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple gunshot wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

XX Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

4-25-96

28b. Time of Injury

8:35 M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

in car

28f. Location (Street and Number or Rural Route Number, City or Town, State)

800 Block Beaumont Ave

29a. Certifier (Check only one)

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Donald G. Wright MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 25, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13260

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLORIA ADAMS</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>25</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>4:44 P</b>	
4. SOCIAL SECURITY NUMBER <b>578 60 3523</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 23-1956</b>		8. BIRTHPLACE (State or Foreign Country) <b>WASH DC</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>Southern Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>CLINTON</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>ALLEGIS HLTH + REHAB CTR</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>N/A</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OFFICE CLEANER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIE ADAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>N/A WILLY GHHN</b>					
19a. INFORMANT'S NAME (Type/Print) <b>JANE LINDSEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9211-STUART LANE CLINTON MD 20735</b>					
20a. MANNER OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b> <b>State rem.</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ANATOMY BOARD</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph B. Van Sant</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS WITH SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Acquired Immunodef. Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebral Neoplasm</b> DUE TO (OR AS A CONSEQUENCE OF): <b>malnutrition</b>								Approximate interval Between Onset and Death <b>7 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES NO UNCERTAIN</b>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>							
29c. LICENSE NUMBER <b>D46478</b>				29d. DATE SIGNED (Month, Day, Year) <b>3-27-96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Suresh A. Patel, MD 7501 Surrahts Rd. #302, Clinton, MD 20735</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

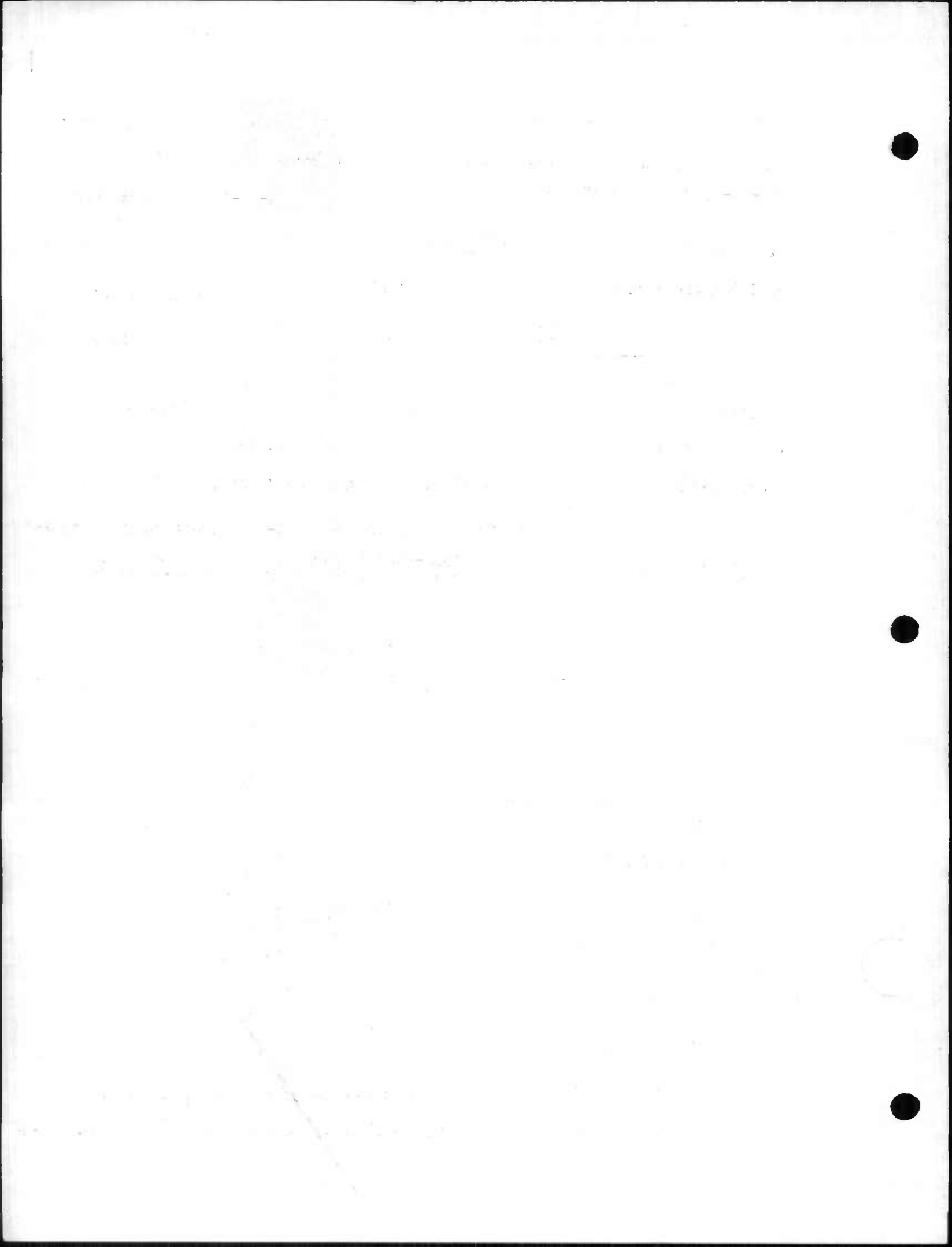
State of Maryland / Department of Health and Mental Hygiene

96 13261

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie <del>Beddows</del> Gertrude Beddows				2. Date of Death Month Day Year May 3 1996		3. Time of Death 4:45 AM	
	4e. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-38-7450		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 06-01-1913	
	9. Birthplace (State or Foreign Country) Virginia		10e. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10f. Zip Code 21222		10g. Citizen of What Country? United States		10a. Street and Number 6533 Parnell Avenue	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 years		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Robert Shifflett	
	18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		18b. Kind of Business/Industry Own Home		18. Mother's Name (First, Middle, Maiden Surname) Sarah Frazier		19. Informant's Name/Relationship (Type, Print) Linda Beddows	
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6533 Parnell Avenue Baltimore, Maryland 21222		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gdns		20c. Location - City or Town, State Middle River, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Dudd-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <u>ischemic cardiomyopathy</u> Due to (or as a consequence of): b. <u>coronary artery disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death > 20 years > 20 years	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospitel: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number L2903 - A54147357		29d. Date signed (Month, Day, Year) May 3 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Elen Lawrence Johns Hopkins Hospital 600 N. Wolfe St Baltimore MD 21287	
	31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature 		33. State Registrar 15		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13262

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHIRLEY BARRASH</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>8:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-26-4996</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 26, 1929</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10a. Street and Number <b>7202 ROCKLAND HILLS DR., APT. 108</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROCESSOR</b>		16b. Kind of Business/Industry <b>BANKING</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOSEPH RICHMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BESSIE KAM</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>DAVID BARRASH (STEP-SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 HARROD CT. REISTERSTOWN, MD 21136</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOGAN ABRAHAM (ADATH YESHURUN)</b>		20c. Date <b>4/30/96</b>		20d. Location - City or Town, State <b>ROSEDALE, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC BREAST CA</b>							
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>A.J. IMPERIAL, Jr. MD</b>		29c. License number <b>D44505</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NWHC</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

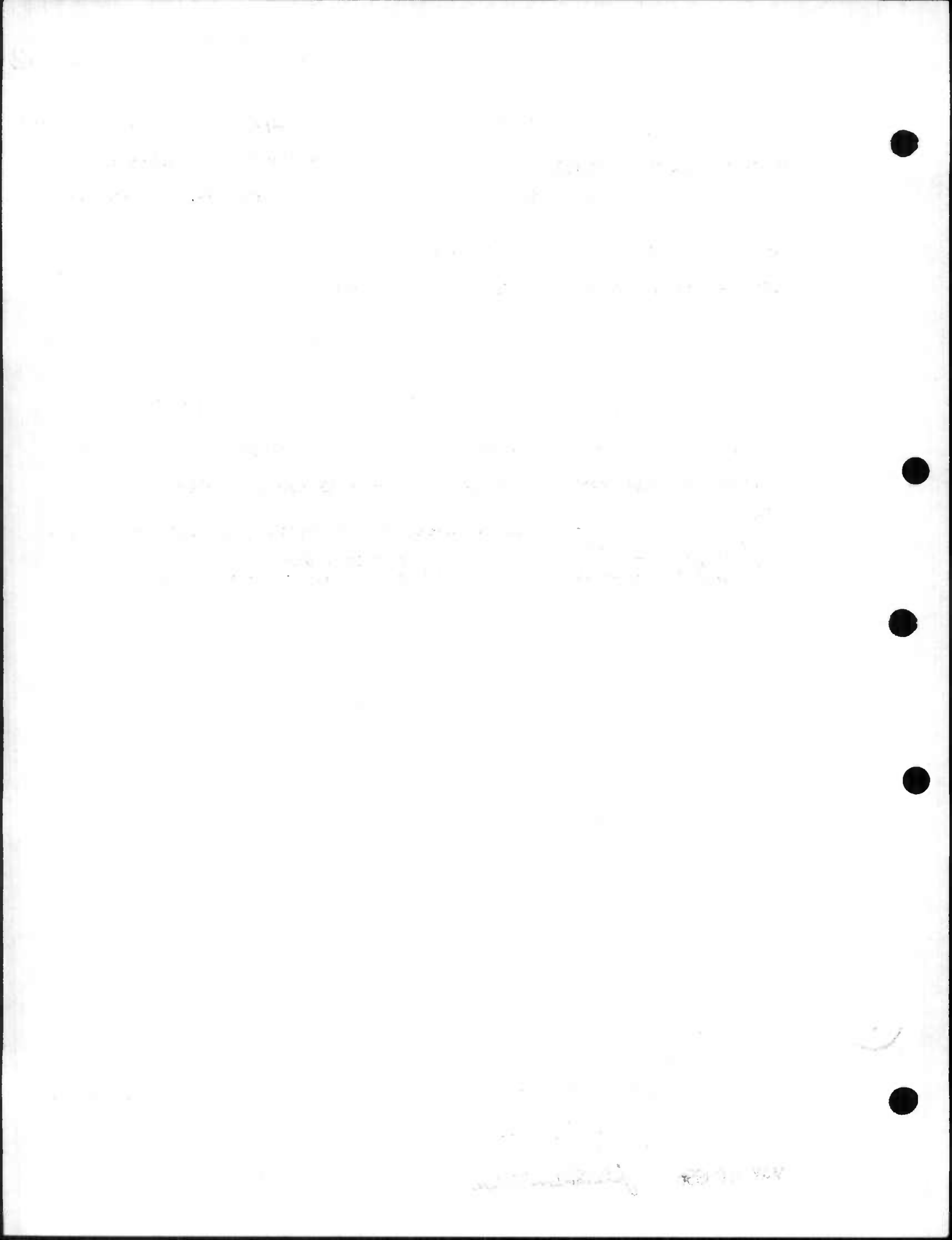
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13263

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Babb</b>		2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>3:28 pm</b>
	4e. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>		4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>
Funeral Director	5. Social Security Number <b>249 32 5703</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 21, 1926</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>		
Usual Residence of Decedent					
10e. State <b>Virginia</b>		10b. County <b>Accomack</b>		10c. City, Town or Location <b>Chincoteague</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>5421 Misty Meadows Drive</b>		10f. Zip Code <b>23336</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1950</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>Sampe Babb</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Leslie Pittman</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Catherine E. Babb (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5421 Misty Meadows Drive Chincoteague, Va. 23336</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem Gardens</b>		20c. Location - City or Town, State <b>5/7/1996 Baltimore County, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>Interstitial Pulmonary Fibrosis</b>					
Due to (or as a consequence of):					
b. <b>Lung man</b>					
Due to (or as a consequence of):					
c. <b>Renal Failure</b>					
Due to (or as a consequence of):					
d.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>H43617</b>		29d. Date signed (Month, Day, Year) <b>5/4/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11220 Beachcomber Rd Berlin MD 21811</b>					
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

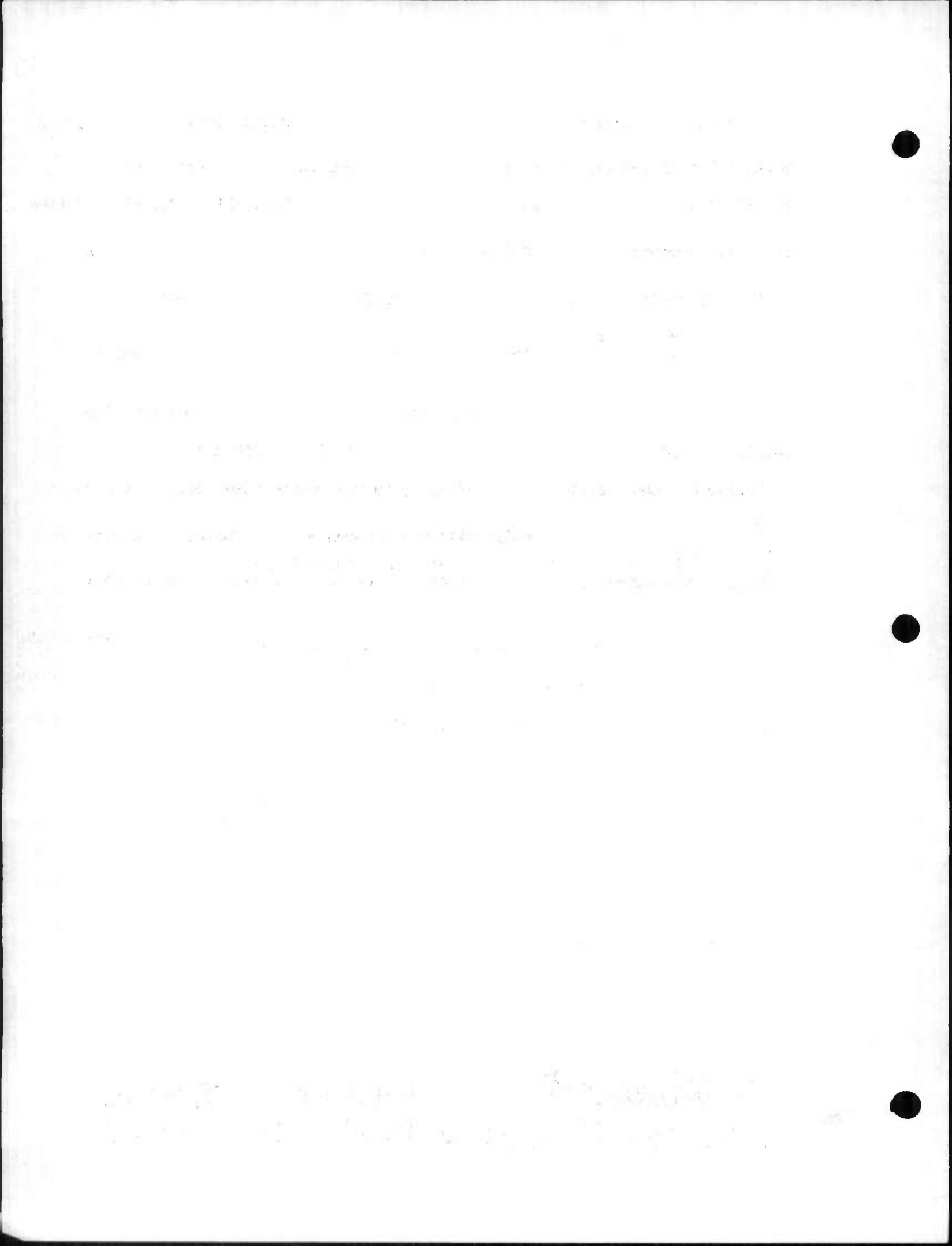
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13264

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVAN J. BLOCK

2. Date of Death  
Month Day Year

MAY 2 1996

3. Time of Death

1:10 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

217-09-6462A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 13, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 POMONA EAST, APT. 301

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CONTRACTOR

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

HARRY

BLOCK

18. Mother's Name (First, Middle, Maiden Surname)

~~ANNA~~

Anna

KING

19a. Informant's Name/Relationship (Type, Print)

MRS. SHIRLEY BLOCK (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 POMONA EAST, APT. 301 BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHOFETZ CHAIM

Date

5-3-1996- ROSEDALE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL HEMORRAGE

Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43462

29d. Date signed (Month, Day, Year)

MAY 2 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. RAO, M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

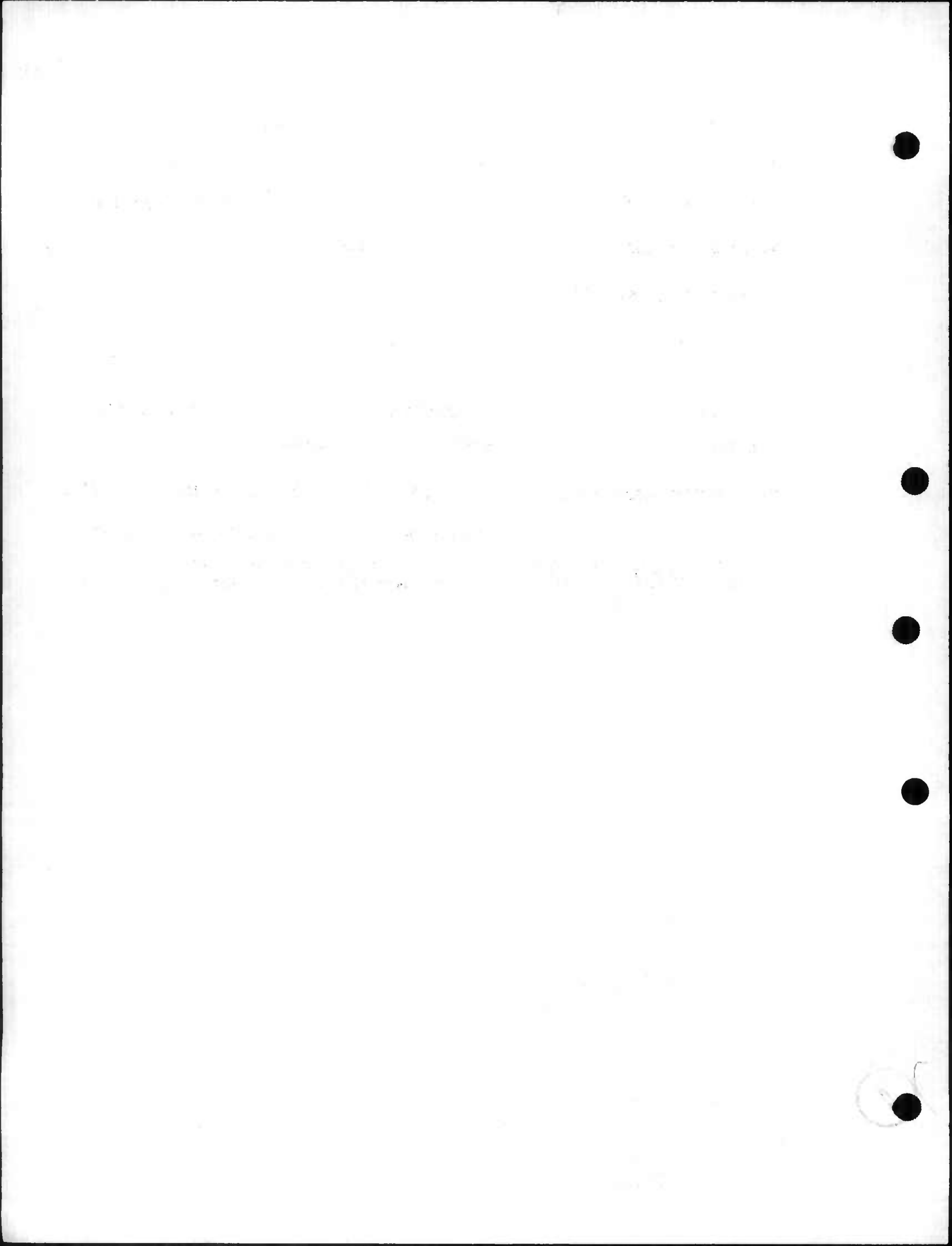
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

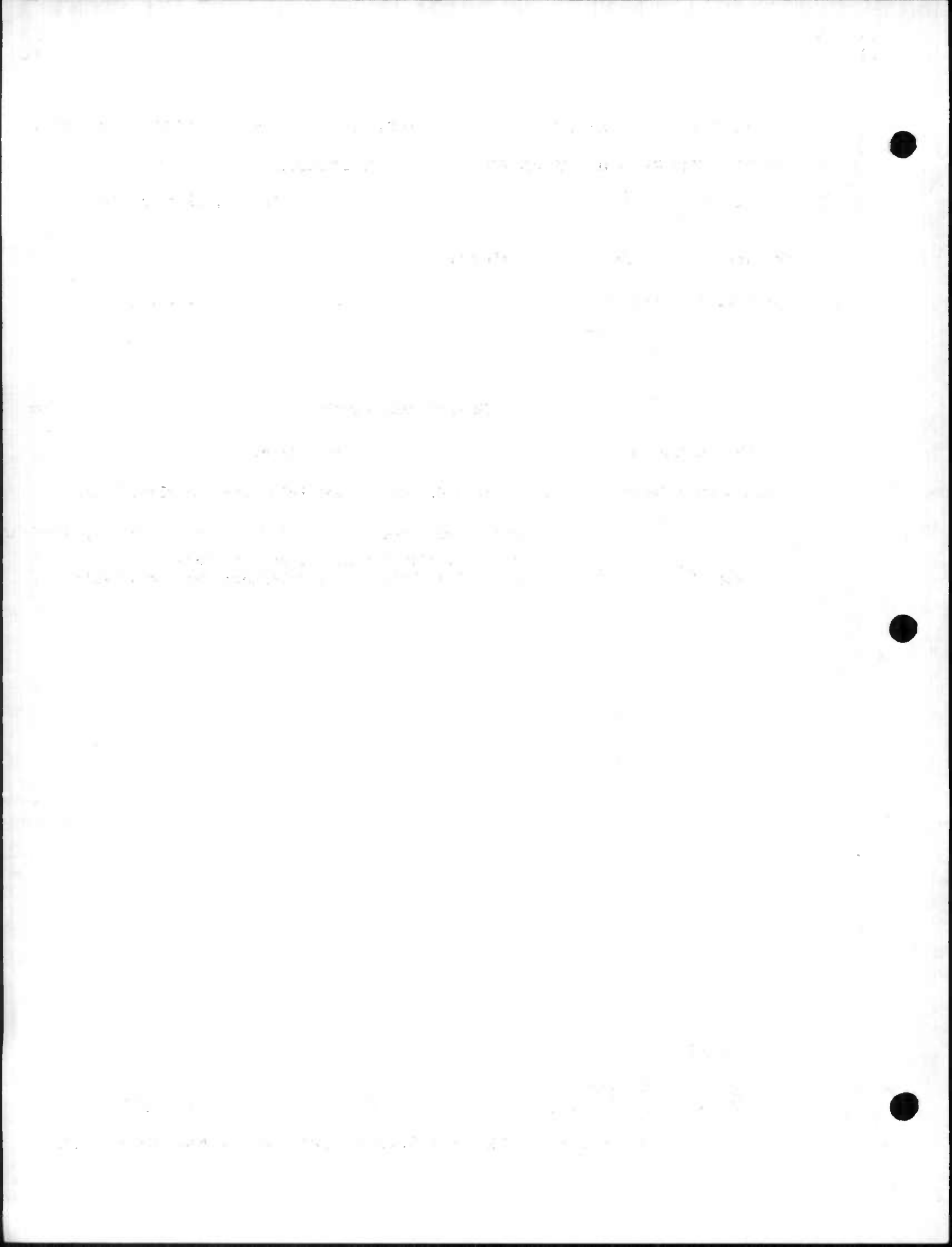
96 13265

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM RILEY BURTON</b>				2. Date of Death Month Day Year <b>MAY 03, 1996</b>		3. Time of Death <b>19:05 P</b>					
	4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL ER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/a</b>					
Funeral Director	5. Social Security Number <b>219-16-9088</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 10, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1403 W. 36th Street</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>U.S.A.</b>								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bureau of Sanitation</b>			16b. Kind of Business/Industry <b>Bureau of Sanitation</b>							
17. Father's Name (First, Middle, Last) <b>Thomas Burton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Miller</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Faison White/Brother-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1403 W. 36th Street Baltimore, Maryland 21211</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crest Lawn Gardens</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Marriottsville, Maryland</b>						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave, Baltimore, Maryland 21211</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic alcoholism</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
						24e. Was an autopsy performed? <b>partial</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 							29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>MAY 04, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>												
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13266

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>JOSEPH MICHAEL CAMILLE</b>					2. Date of Death Month <b>May</b> Day <b>04</b> Year <b>96</b>		3. Time of Death <b>1902</b>			
	4a. Facility Name (If not institution, give street and number) <b>Kimbrough Army Community Hospital</b>					4b. City, Town, or Location of Death <b>Ft. Meade</b>		4c. County of Death <b>AA</b>			
<b>Funeral Director</b>	5. Social Security Number <b>026-34-8492</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 04 44</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severn</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>7825 Citadel Drive</b>				10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1960</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Trucking</b>				
17. Father's Name (First, Middle, Last) <b>Joseph Camille</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Souza</b>						
					19a. Informant's Name/Relationship (Type, Print) <b>Kenneth W. Camille / Brother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7825 Citadel Dr. Severn, MD 21144</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Orange Hill Cemetery May 8, 1996</b>		Data		20c. Location - City or Town, State <b>Williston, Florida</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>Acute Cardiac Arrhythmia</b></p> </div> <div style="width: 60%;"> <p>a. Due to (or as a consequence of): <b>Arteriosclerotic Heart Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div>										Approximate Interval Between Onset and Death <b>Unk</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  deputy			29c. License number <b>D 06054</b>		29d. Date signed (Month, Day, Year) <b>May 04 96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, M.D. 695 America Court 21035</b>											
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6+1



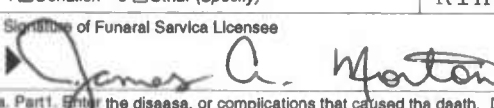
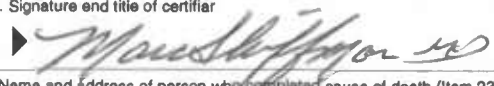

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13267

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALEXANDER COOK</b>				2. Date of Death Month <b>MAY</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>12:59PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>228-07-0936</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 28, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>VA</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>2031 Cliftwood Ave.</b>			
	10f. Zip Code <b>21213</b>				10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Crane Operator</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>			
	17. Father's Name (First, Middle, Last) <b>Dock Cook</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Polly Jackson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Pearl Purnell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1502 Pentwood Rd. Balto., MD 21239</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Pk.</b>		20c. Date <b>5/9/96</b>		20d. Location - City or Town, State <b>Randallstown, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>James A. Morton &amp; Sons Funeral Home 1701 Laurens St. Balto., MD 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARREST</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>29 MIN.</b> <b>5 DAYS</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARRIAL FIBRILLATION</b> <b>CARDIOMYOPATHY</b> <b>GOITER</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>E9041</b> <b>D37304</b>		29d. Date signed (Month, Day, Year) <b>5.4.96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marc Shiffman MD Johns Hopkins Hospital 600 W Wolfe St Balto MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13268

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Regenia Chambers				2. Date of Death Month 1, Day 1996 Year		3. Time of Death 3:10 PM		
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death n/a		
Funeral Director	5. Social Security Number 219-32-0508		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) March 19, 1898		
	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number 1700 Eutaw Place apt. 1D				10f. Zip Code 21217		10g. Citizen of What Country? USA	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Domestic			
		17. Father's Name (First, Middle, Last) John T. Turner		18. Mother's Name (First, Middle, Maiden Surname) Sarah Griffin					
		19a. Informant's Name/Relationship (Type, Print) Beverly Veney		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 946 Durham st. Baltimore, MD 21205					
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National		Date 5/6/96		20c. Location - City or Town, State Baltimore, MD	
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Urosepsis Due to (or as a consequence of): Cardiomyopathy Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death days years unknown					
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia due to A-V Malturmation				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 89246		29d. Date signed (Month, Day, Year) May 1, 1996	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luis Mejico, M.D. c/o Maryland General Hospital							
State Registrar		31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13269

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LENA CRISTY</b> Adelaida Cristy				2. Date of Death Month <b>04</b> Day <b>29</b> Year <b>96</b>		3. Time of Death <b>10064</b>	
	4a. Facility Name (If not institution, give street and number) <b>Church Home Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-01-0428</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 10, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2400 Sparrows Point Road</b>				10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Restauranteur</b>			16b. Kind of Business/Industry <b>Food</b>	
17. Father's Name (First, Middle, Last) <b>Giovanni Papparotto</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Filomena Granello</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald J. Cristy (Son)</b>				19b. Mailing Address <b>Carrbridge 8341 Carrbridge Circle Towson, Maryland 21204</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>5/2/96</b> <del>5/1/96</del>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Johnny L. Gille</b>				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. NON-HODGKINS LYMPHOMA</b>								<b>1 MONTH</b>
Due to (or as a consequence of): <b>b. PANCYTOPENIA</b>								<b>1 MONTH</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. SEIZURE DISORDER</b>								<b>1 WEEK</b>
Due to (or as a consequence of): <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. Krishna</b>				29c. License number <b>D29071</b>		29d. Date signed (Month, Day, Year) <b>4-29-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. KRISHNAN, MD 821 N. EUTAW ST. #305 BALTIMORE 41201</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Una Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4





96 13270

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bennett</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 4 1996</b>				3. TIME OF DEATH <b>6:15A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-30-3140</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 18, 1934</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3623 Elm Avenue</b>				10f. ZIP CODE <b>21211</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Maryland Dry Ice</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Elroy Downs</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Viola Parks</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mechel Downs</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3623 Elm Ave, Baltimore, Maryland 21211</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lake View Mem Park 5/7/96</b>				20c. LOCATION — City or Town, State <b>Sykesville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>A. Alan Seitz, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave, Baltimore, Maryland 21211</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>25 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert McKinney, D.O.</b>				29c. LICENSE NUMBER <b>AT 2438946</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/4/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert McKinney, D.O. Union Memorial Hospital</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13271

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARILYN DOYLE</b>				2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>18:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>024-28-1056</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 14, 1937</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Howard County</b>		10c. City, Town or Location <b>Ellicott City</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3431 Arcadia Drive</b>				10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>6</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foreign Language Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		
17. Father's Name (First, Middle, Last) <b>Francis H. Norton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Hayes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Robert J. Doyle (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3431 Arcadia Drive, Ellicott City, MD 21042</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John Cemetery</b>		Date <b>5/4/96</b>		20c. Location - City or Town, State <b>Ellicott City, MD</b>		
21. Signature of Funeral Service Licensee <b>Brian L. Haight</b>				22. Name and Address of Facility <b>HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MARANTIC ENDOCARDITIS</b> Due to (or as a consequence of): <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): <b>OCCCLUSION OF CORONARY OSTIUM</b> Due to (or as a consequence of):  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>WEEKS</b> <b>5 DAYS</b> <b>1 DAY</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Status Post gastrectomy for Adenocarcinoma</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Bert F. Morton M.D.</b>						
		29c. License number <b>D08949</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Bert F. Morton St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		Registrar's Signature <b>John Taylor-Ross</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13272

Item: 8 \$18 per F.H. G-736 6/3/96 reb Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Daiger</b>					2. Date of Death Month <b>May</b> Day <b>02</b> Year <b>1996</b>		3. Time of Death <b>12:50 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>7200 Third Ave.</b>					4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>		
<b>Funeral Director</b>	5. Social Security Number <b>577 80 3805</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>99</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 4, 1897</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7200 Third Ave.</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4or 5+) <b>+4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>			16b. Kind of Business/Industry <b>Alex. Brown</b>			
17. Father's Name (First, Middle, Last) <b>Benjamin W. Hazell</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Mary A. Hofnagle HOOFNAGLE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gordon W. Daiger</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6402 Winston Drive Bethesda, Md. 20817</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation</b>		Date <b>5/4/96</b>		20c. Location - City or Town, State <b>Hampstead, Md.</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PNEUMONIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>2 Weeks</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D22220</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ellis Moe 1645 Liberty Road Eldersburg, MD. 21784</b>										
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13273

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DALE FORD

2. Date of Death

MAY 2, 1996

3. Time of Death

23:10 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

SINAI HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

214 88 0811

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEP 30, 1962

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2404 LOYOLA NORTHWAY T2

10f. Zip Code

21215

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH

College (1-4 or 5+)

none

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

RONALD FORD

18. Mother's Name (First, Middle, Maiden Surname)

DORIS LORRAINE WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

GALE FORD (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2404 LOYOLA NORTHWAY T2 BALTO., MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

KING MEM. PARK MAY 8, 1996

Date

20c. Location - City or Town, State

BALTO. CO.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215

4517 PARK HEIGHTS AVE. BALTO., MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Gunshot Wounds of Abdomen and Back

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☒ Homicide28a. Date of Injury  
(Month, Day, Year)

5/2/96

28b. Time of  
injury

2240 M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)4316 Reisterstown  
Road Baltimore Maryland29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King md.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 3, 1996

30. Name and address of person who completed cause of death (If in 23a) (Type, Print)

THEODORE M. King

111 PENN STREET BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

MAY 6 1996

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
to the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


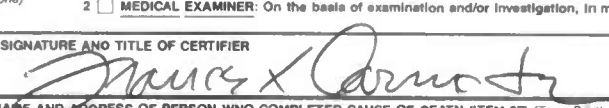
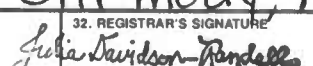




96 13274

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Mary Frisino				2. DATE OF DEATH May 01 1996 YEAR		3. TIME OF DEATH 6:45 A M	
4. SOCIAL SECURITY NUMBER 212-12-6707		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25 1908	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 500 Hatherleigh Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Stoneleigh		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Stoneleigh	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 500 Hatherleigh Rd.			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Keeper		16b. KIND OF BUSINESS/INDUSTRY Banking			
17. FATHER'S NAME (First, Middle, Last) Andrew Fiedler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Wagner			
19a. INFORMANT'S NAME (Type/Print) Margaret McLeary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Haddington Rd. Lutherville, Md. 212093			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. DATE 5-4-96		20d. LOCATION — City or Town, State Parville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 001373		29d. DATE SIGNED (Month, Day, Year) 5/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis Carmody, 7505 Osler Dr, 21204							
31. DATE FILED (Month, Day, Year) MAY 06 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13275

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS EVERETT FLANIGAN</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>2:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-44-1309</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 3, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Ft. Howard</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8620 Tail Oak Rd.</b>		10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs</b> College (1-4 or 5+) <b>4 yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Maryland Rehabilitation Center</b>			
	17. Father's Name (First, Middle, Last) <b>William F. Everett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie E. Granlund</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Kathleen F. Balcer - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. Location - City or Town, State <b>5/6/96 Baltimore, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Paul L. Hartsock, Jr.</b>		22. Name and Address of Facility <b>Baltimore, MD 21214</b> <b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>					
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Aspiration Pneumonia</b></p> <p>b. <b>Poor Pulmonary Toilet</b></p> <p>c. <b>Recurrent Cerebral Ischemia</b></p> <p>d. <b>Senile Dementia</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>3 Days</b></p> <p><b>6 months</b></p> <p><b>Days</b></p> <p><b>3 yrs</b></p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid Arthritis severe</b> <b>Congestive Cardiomyopathy</b> <b>Chronic Atrial Fibrillation</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Michael J. Ruck</b>				29c. License number <b>927693</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. Ruck MD 4530 Walters Ave Baltimore</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>Julia Anderson-Randall</b>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

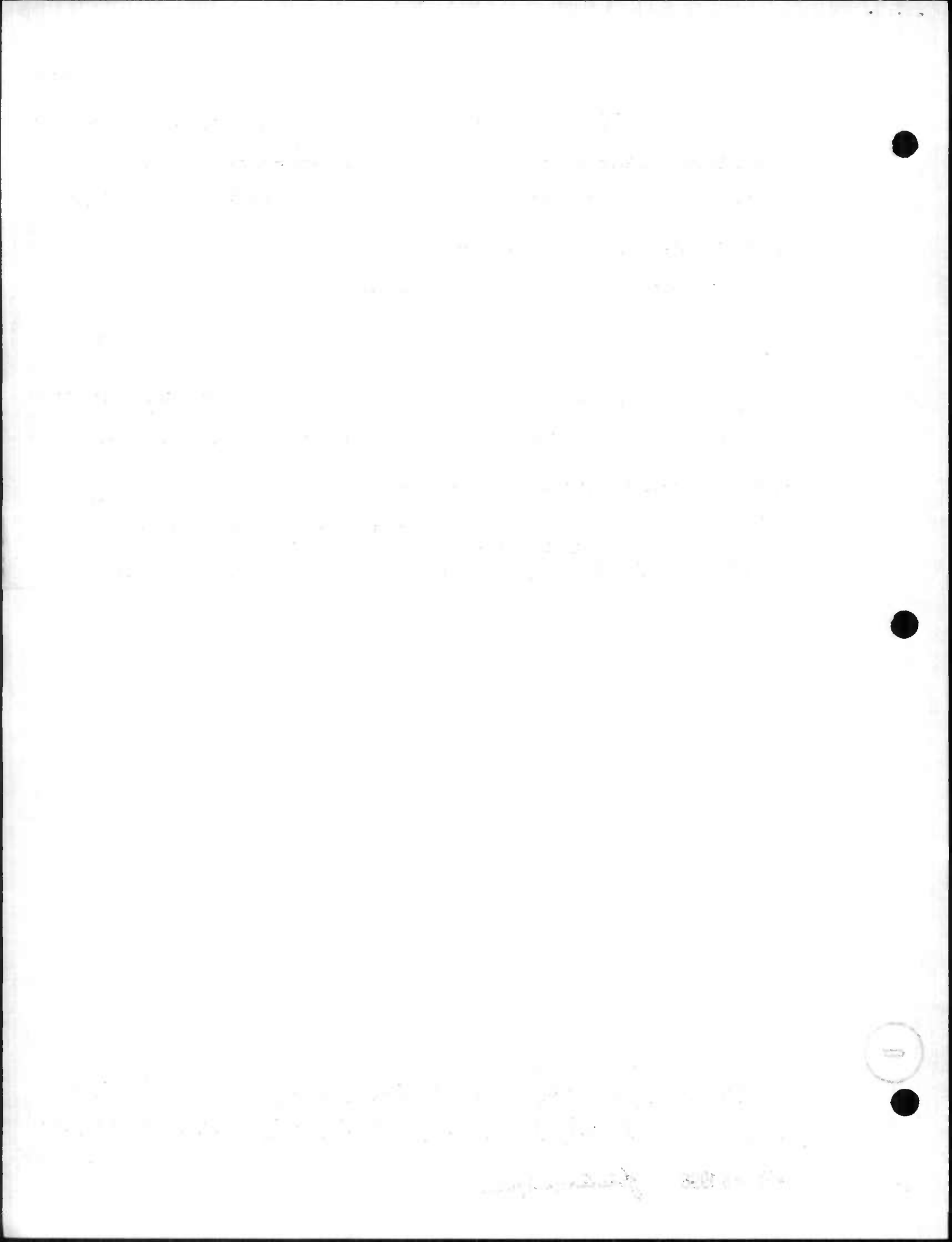
Division of Vital Records, P.O. Box 68760,

In the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



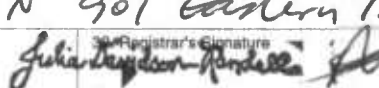
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13276

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ernest Tyler Ferguson</b>				2. Date of Death Month <b>May</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>6:03 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3922 Corse Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore, City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>009-01-7261</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 19, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Vermont</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore, City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3922 Corse Ave.</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>		16b. Kind of Business/Industry <b>Basement Water Proffing</b>				
17. Father's Name (First, Middle, Last) <b>James Leland Ferguson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Tyler</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Ruth H. Ferguson - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10e</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Town Cemetery</b>		Date <b>5/7/96</b>		20c. Location - City or Town, State <b>Sudbury, Massachusetts</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road - Baltimore, Maryland 21214</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Refractory Pancytopenia</b> Due to (or as a consequence of): <b>Bone Marrow Failure</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD, H/O Myocardial Infarction</b> <b>Atrial Fibrillation</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>D19133</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. HAROUN 901 Eastern Blvd 21221</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

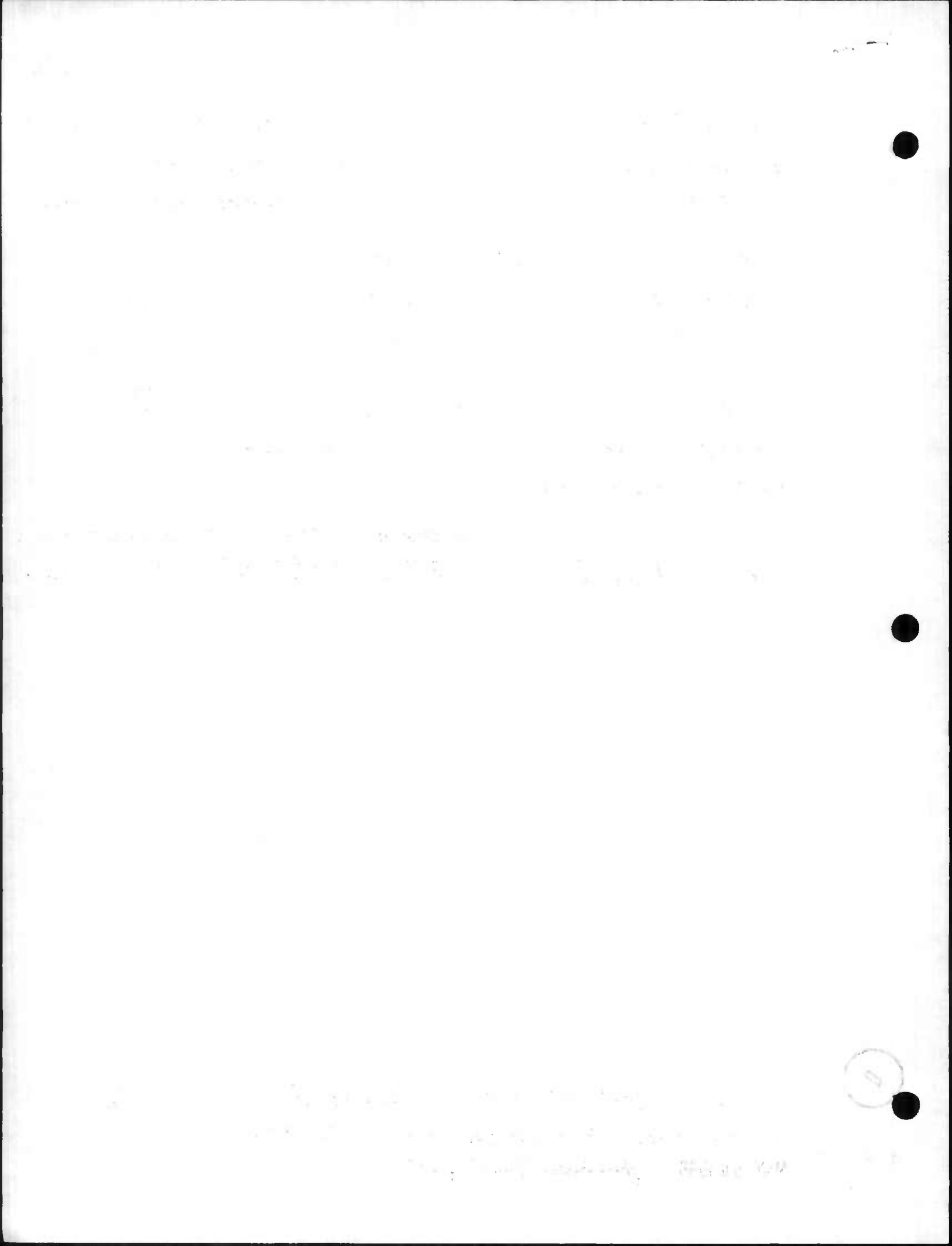
The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Certificate of Death

96 13277

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRIAN BRUCE FINK				2. Date of Death Month Day Year MAY 03, 1996		3. Time of Death 0035AM			
	4a. Facility Name (If not institution, give street and number) SOUTHBOUND NORTHPOINT BOULEVARD				4b. City, Town, or Location of Death NORTHPOINT		4c. County of Death BALTIMORE COUNTY			
Funeral Director	5. Social Security Number 213-70-3847		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-27-1956	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 435 S. 52nd Street				10f. Zip Code 21224		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1976-77		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) 12 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) William Henry Fink, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Theresa Bingnear					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. and Mrs. William H. Fink, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 S. 52nd Street Baltimore, Maryland 21224					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest V.A. Cem.		Date 05-06		20c. Location - City or Town, State Owings Mills, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5/2/96		28b. Time of injury 2320 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject - pedestrian struck by vehicle		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) North Point Boulevard near Eastern Avenue, Baltimore County Maryland						
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 03, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. K... 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature 								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13278

Item 1, Film 735/5/6/96, 1t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARCEL Claire MARCELLE FOSTER</b>				2. Date of Death Month Day Year <b>May 4, 1996</b>		3. Time of Death <b>11:25 Pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore Co.</b>	
Funeral Director	5. Social Security Number <b>018-18-4278</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 18, 1921</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>	
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>53 Rockywood Lane</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Restaraunt</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary Jane Walker/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53 Rockywood Lane Essex, Md. 21221</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham Veterans Cemetery</b>		Date <b>5/8/96</b>		20c. Location - City or Town, State <b>Cheltenham, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Brian A. Willem</b>				22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of): <b>b. Cor Pulmonale</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>20 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>						
29c. License number <b>D45475</b>		29d. Date signed (Month, Day, Year) <b>5/5/96</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mohammad Rahnama, MD 9000 Franklin Square Drive Baltimore, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13279

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MYRTLE M. GEPPERT</b>				2. Date of Death Month <b>MAY</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>10:45 pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-16-2914</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 2, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>40 Acorn Circle</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>John Wachter</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Schneider</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Paul F. Geppert (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>40 Acorn Circle Towson, Maryland 21286</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		Date <b>5/8/96</b>		20c. Location - City or Town, State <b>Baltimore Maryland</b>		
21. Signature of Funeral Service licensee <b>Milton J. Knight Jr.</b>				22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ACUTE MYOCARDIAL INFARCTION</b>								Approximate Interval Between Onset and Death <b>4 WEEKS</b>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Joginder P. Mehta M.D.</b>		29c. License number <b>D 41410</b>		29d. Date signed (Month, Day, Year) <b>May 5th, 96.</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOGINDER P. MEHTA, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13280

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD JAVUS

GROOM

2. Date of Death  
Month Day Year

MAY 3, 1996

3. Time of Death

4:35 PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

220-07-9599

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 11, 1912

9. Birthplace (State or Foreign Country)

Towson, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33 Northwood Drive

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurant Owner

16b. Kind of Business/Industry

Restaurant/Food

17. Father's Name (First, Middle, Last)

Harry Groom

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Wilson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nina G. (nee Fritts) Groom (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33 Northwood Drive Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Prospect Hill Cem.

Date

5/07/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial infarction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert Stoltz, MD

29c. License number

1730510

29d. Date signed (Month, Day, Year)

5/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Stoltz, MD 1447 York Rd Luthersville, MD

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia Wilson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13281

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Franklin Glantz</b>						2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>7:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>942 Wilton Drive</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-30-5357</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 9, 1936</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>942 Wilton Drive</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Sheet Metal</b>			
17. Father's Name (First, Middle, Last) <b>William Garrison Glantz</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Beaucard</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carol A. Glantz/wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>942 Wilton Drive Baltimore, MD 21227</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>			Date <b>05/07/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>						22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>Hypoglycemia - SHOCK</b> Due to (or as a consequence of): <b>Diabetic Mellitus Insulin Dependent</b> Due to (or as a consequence of): <b>Diabetic Interderm - Peripneum</b> Due to (or as a consequence of): <b>Gangrene both Feet</b></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death <b>24 hrs</b> <b>20 yrs</b> <b>10 yrs</b> <b>6 mo</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of certifier <b>Benjamin Berdman M.D.</b>						29c. License number <b>D00751</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENJAMIN BERDMAN 606 HAMMONDS LANE BALTO MD 21225</b>										
31. Date filed (Month, Day, Year) <b>5-6-96</b>			32. Registrar's Signature <b>MAY 06 1996 Julia Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13282

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rose Gonzalez</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>2:45 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare - Homewood Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>087-03-6301</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 30, 1903</b>	
	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>823 Loyola Drive</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Puerto Rican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Factory</b>			
	17. Father's Name (First, Middle, Last) <b>Jesus Gonzalez</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Rios</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Christine M. Gonzalez/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>823 Loyola Drive Towson, MD 21204</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Date <b>05/04/96</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CA. OF THE BREAST WITH METASTASIS</b> (6 MONTHS) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Senile Dementia</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>D. Matus M.D. Cert. Physician</b>				29c. License number <b>D14618</b>		29d. Date signed (Month, Day, Year) <b>May 4, 1996</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BIENVENIDO R MATOS 21 CRANBROOK RD COCKEYSVILLE, MD 21030</b>							
	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>							



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State of Maryland / Department of Health and Mental Hygiene

96 13283

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIAN T. GROSS</b>				2. Date of Death Month <b>MAY</b> Day <b>02</b> Year <b>1996</b>		3. Time of Death <b>8:28 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212 36 5160</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 22, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3600 Clarks Lane</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>AT HOME</b>			
	17. Father's Name (First, Middle, Last) <b>BENJAMIN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>TOBESMAN FLORENCE</b>		19. Informant's Name/Relationship (Type, Print) <b>HERBERT M. GROSS (HUSBAND)</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS</b>		20c. Location - City or Town, State <b>5/3/96 OWINGS MILLS, MD</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b>		23a. Past: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Overwhelming pneumonia</b> Due to (or as a consequence of): <b>Respiratory failure</b> Due to (or as a consequence of): <b>Septic shock, renal failure</b> Due to (or as a consequence of): <b>Constrictive heart failure</b>		Approximate Interval Between Onset and Death <b>6 hrs</b> <b>5 weeks</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5/3/96</b>		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>DD9 775</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stanley M. Rosenberg 2435 W. Belvedere Ave. Baltimore 21215</b>		31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**septic shock, perineural and ischiorectal abscess, renal failure**  
**Asplenic Cardiovascular Disease**

23b. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)27. Manner of Death  
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined28a. Date of Injury (Month, Day, Year)  
**5/3/96**28b. Time of Injury  
**M**28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier  
*[Signature]*29c. License number  
**DD9 775**29d. Date signed (Month, Day, Year)  
**5/3/96**30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**Stanley M. Rosenberg 2435 W. Belvedere Ave. Baltimore 21215**31. Date filed (Month, Day, Year)  
**MAY 06 1996**32. Registrar Signature  
*[Signature]*



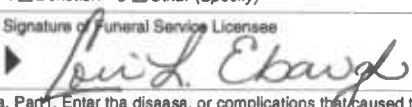


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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

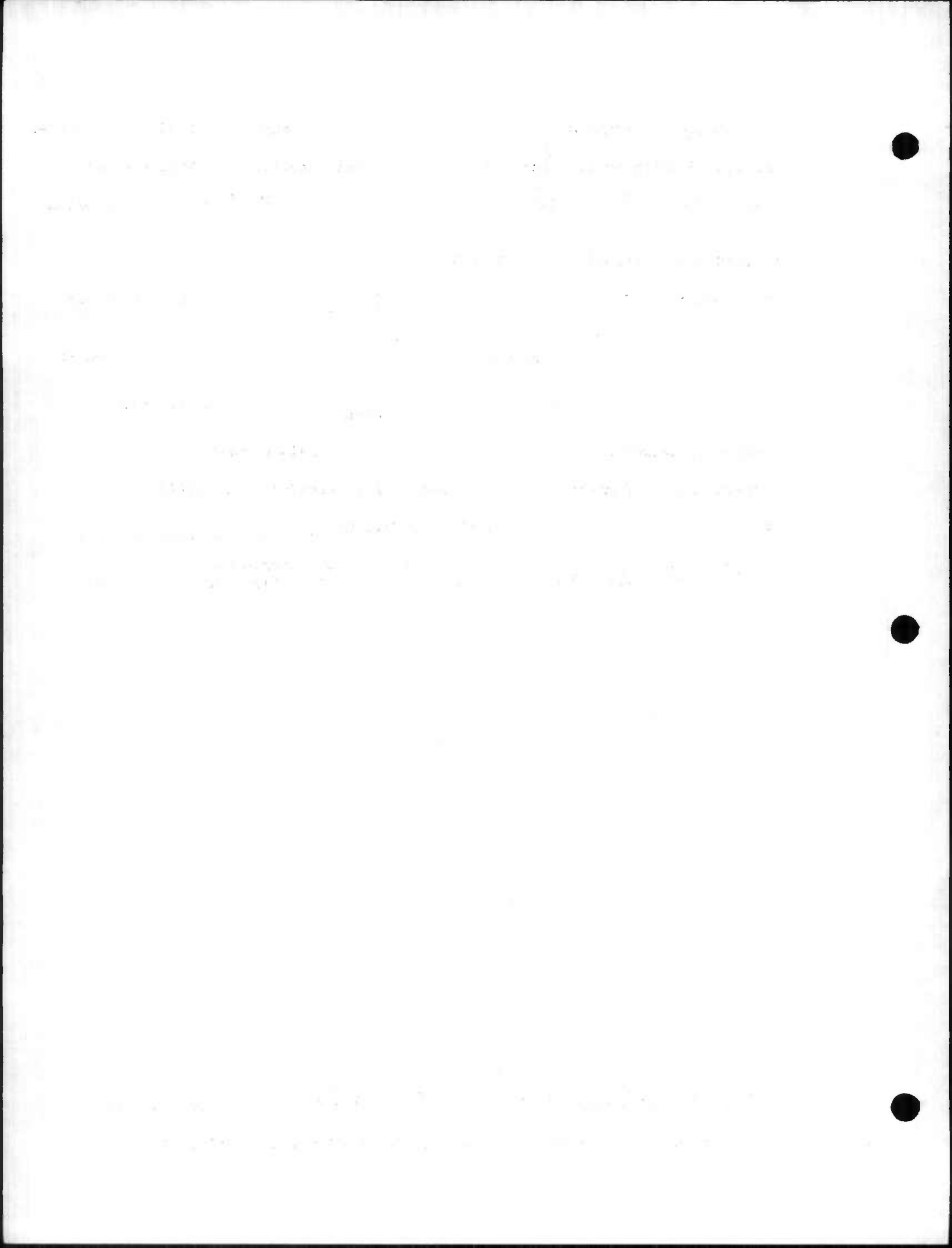
Reg. No.

96 13284

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Higley W. Harmon Jr.</b>				2. Date of Death Month Day Year <b>May 4 1996</b>		3. Time of Death <b>3:00 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Knollwood Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Millersville</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>244-14-8748</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 4, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>S. Carolina</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8147 Solley Road</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1940-49</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrician</b>		18b. Kind of Business/Industry <b>Contracting</b>			
	17. Father's Name (First, Middle, Last) <b>Higley W. Harmon Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Avis Dempsey</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lynette Deyhoff/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8147 Solley Rd. Pasadena, Md 21122</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham MD Vet. Cem.</b>		Data <b>May 9, 1996</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Failure</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Dementia</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>6 months</b> <b>1 month</b> <b>3 yrs</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Cardiovascular Disease</b> <b>Tube Feeder - Total Care Patient</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number <b>114753</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Robert B. Kroopnick 795 Aquahart Drive Glen Burnie, MD 21061</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13285

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Hetterman				2. DATE OF DEATH MONTH DAY YEAR April 16, 1996		3. TIME OF DEATH 11:50 a m	
4. SOCIAL SECURITY NUMBER 212-03-8584		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 17, 1916	
8. BIRTHPLACE (State or Foreign Country) PA				9a. FACILITY NAME (If not Institution, give street and number) 407 Doefield Drive		9b. CITY, TOWN OR LOCATION OF DEATH Manchester	
9c. COUNTY OF DEATH Carroll				10a. STATE MD		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 402 Lorraine Avenue	
10f. ZIP CODE 21221				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria		16b. KIND OF BUSINESS/INDUSTRY Food Service	
17. FATHER'S NAME (First, Middle, Last) William Sigel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel Crawford			
19a. INFORMANT'S NAME (Type/Print) Marvelene Mae McMillion				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Doefield Drive Manchester, MD 21102			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Lutheran Cemetery 4/20/96		20c. LOCATION — City or Town, State Warfordsburg, PA 17267	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Renee S. Moore</i>				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Cardiac arrhythmias Ischemic heart disease  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Cerebrovascular Accident - Congestive heart failure  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate Interval Between Onset and Death 1 day 10 yrs.
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending</i>				29c. LICENSE NUMBER D-16444		29d. DATE SIGNED (Month, Day, Year) April 25th 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIJAY S. NAIR M.D. 2112 BELAIR ROAD. FALLSTON, MD 21047.							
31. DATE FILED (Month, Day, Year) MAY 08 1996				32. REGISTRAR'S SIGNATURE <i>John Arundel Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 13286

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACQUELINE HURTT</b>		2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 24 1996</b>		3. TIME OF DEATH <b>12:01 P.M.</b>
4. SOCIAL SECURITY NUMBER <b>212-16-9749</b>	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>35</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>September 6, 1958</b>	
8a. FACILITY NAME (If not Institution, give street and number) <b>Church Hospital</b>		8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>None</b>
10a. STATE <b>Maryland</b>		10b. COUNTY <b>None</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>629 N. Mount Street</b>		10f. ZIP CODE <b>21217</b>
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>
17. FATHER'S NAME (First, Middle, Last) <b>Robert Hurtt</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Delores Back</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Robert Hurtt</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>629 N. Mount Street Baltimore, Md 21217</b>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mr. Zion 4/24/96</b>		20c. LOCATION — City or Town, State <b>Lansdowne, Maryland</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Russell M. Greene</b>		22. NAME AND ADDRESS OF FACILITY <b>Whelan Funeral Service 3405 W. Franklin St. Baltimore, Md 21229</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AORTIC VALVE REGURGITATION</b> Due to (or as a consequence of): b. <b>BACTERIAL ENDOCARDITIS</b> Due to (or as a consequence of): c. <b>INTRAVENOUS DRUG ABUSE</b> Due to (or as a consequence of): d. <b>INTRAVENOUS DRUG ABUSE</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mickey Valyasev MD</b>		29c. LICENSE NUMBER <b>MD D45525</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 24 1996</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICKEY VALYASEV MD CHURCH HOSPITAL, BALTIMORE MARYLAND</b>				
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>		

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



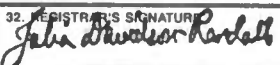
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



96 13287

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lawrence M. Hoffner</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>22</b> YEAR <b>96</b>		3. TIME OF DEATH <b>0308 a.m.</b>		
4. SOCIAL SECURITY NUMBER <b>232-09-0473</b>		5. SEX <b>1</b> M <b>2</b> F	6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-11-1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pierce, WV</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Garrett Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland, Md.</b>		9c. COUNTY OF DEATH <b>Garrett</b>		
RESIDENCE OF DECEDENT								
10a. STATE <b>WV</b>		10b. COUNTY <b>Tucker</b>		10c. CITY, TOWN OR LOCATION <b>Thomas</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		
10e. STREET AND NUMBER <b>PO Box 415</b>				10f. ZIP CODE <b>26292</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10 + GED</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>coal mining</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Mining</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Lawrence Hoffner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Drenning</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Elizabeth Mettica</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 415, Thomas WV 26292</b>				
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery 3-25-96</b>		20c. LOCATION — City or Town, State <b>Thomas, WV</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hinkle Funeral Home, Inc. PO Box 186, Davis WV 26260</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b>								
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> YES <b>2</b> NO		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>1426154</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/22/96</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2008 Maryland Highway, Mt. Lake Park Md. 21550</b>								
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13288

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard F. Idzi</b>				2. Date of Death Month Day Year <b>May 2 1996</b>		3. Time of Death <b>10:20AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>6823 Duluth Ave</b>				4b. City, Town, or Location of Death <b>N/A</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-01-4887</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 2, 1915</b>	9. Birthplace (State or Foreign Country) <b>Louisiana</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md</b>	10b. County <b>Baltimore</b>		10c. City, Town or Location <b>N/A</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6823 Duluth Ave</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Stationary Engineer</b>			16b. Kind of Business/Industry <b>Western Electric</b>	
	17. Father's Name (First, Middle, Last) <b>Frank Idzi</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Izdebski</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Sophia Idzi / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6823 Duluth Ave Baltimore, Md 21222</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Mary 5-6-96</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>			
	21. Signature of Funeral Service Licensee <b>Anthony Colt Connolly</b>				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal Failure</b> Due to (or as a consequence of): <b>Renal Cell CA</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Coronary Artery Disease</b> <b>Parkinsons Disease</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Parkinsons Disease</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>—</b>		28b. Time of Injury <b>—</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>—</b>				28d. Describe how injury occurred <b>—</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Anthony Harrell M.D.</b>		29c. License number <b>D34749</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anthony Harrell, M.D. 2112 Dundalk Ave Baltimore, Md 21222</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Anthony Harrell</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13289

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK P. JAGODZINSKI						2. Date of Death Month Day Year MAY 4, 1996		3. Time of Death 1242 PM	
	4e. Facility Name (If not institution, give street and number) 110 WEST OSTEND STREET						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-14-0726		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) October 26, 1922		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10a. Street and Number 110 West Ostend Street				10f. Zip Code 21230		10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Army If Yes, Give Year or Dates: 1945-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th Grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rigger		16b. Kind of Business/Industry Shipping			
	17. Father's Name (First, Middle, Last) Nicholas Jagodzinski						18. Mother's Name (First, Middle, Maiden Surname) Lena Wunsiewska			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard A. Jagodzinski/Brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 643 South Lakewood Avenue, Baltimore, MD 21224			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery, May 07, 1996		20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <i>Noted</i> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 5, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE McKeig 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 06 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13290

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alberta G. Jelinek</i>						2. Date of Death Month <i>May</i> Day <i>2</i> Year <i>1996</i>		3. Time of Death <i>2:10 PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Church Home &amp; Hospital</i>						4b. City, Town, or Location of Death <i>Baltimore, City</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>216-30-7158</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>60</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 18, 1935</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent										
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore, City</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <i>603 South Ann Street</i>				10f. Zip Code <i>21231</i>		10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>				
17. Father's Name (First, Middle, Last) <i>William Kessler, Sr.</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Ethel Lewis</i>					
19a. Informant's Name/Relationship (Type, Print) <i>John W. Jelinek Son</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8 Banyan Wood Ct. Baltimore, Maryland 21221</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley Memorial</i>			20c. Location - City or Town, State <i>5/6/96 Timonium, Maryland</i>					
21. Signature of Funeral Service Licensee <i>Ronald E. Schaefer</i>						22. Name and Address of Facility <i>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road - Baltimore, Maryland 21214</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Staphylococcus Aureus Sepsis</i> Due to (or as a consequence of): <i>b. End Stage Liver Cirrhosis</i> Due to (or as a consequence of): <i>c. Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): <i>d.</i>										Approximate Interval Between Onset and Death <i>1 month</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>George E. Wicks M.D.</i>				29c. License number <i>D41365</i>		29d. Date signed (Month, Day, Year) <i>May 2, 1996</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>George E. Wicks M.D. 100 North Broadway, Baltimore, MD, 21231</i>											
31. Date filed (Month, Day, Year) <i>MAY 06 1996</i>				32. Registrar's Signature <i>Julia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13291

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLGA KATSIKIDES				2. Date of Death Month Day Year May 6, 1996		3. Time of Death 3:30 A.M.		
	4a. Facility Name (If not institution, give street and number) 6926 Bank Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 217-40-4957	8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 2, 1896	9. Birthplace (State or Foreign Country) Greece		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 6926 Bank Street			10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) Gus Vasiliadis				18. Mother's Name (First, Middle, Maiden Surname) Jean Lirinze				
	19a. Informant's Name/Relationship (Type, Print) Gus D. Katsikides, son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6926 Bank Street, Baltimore, MD 21224				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 5-8-96		20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Matthews Funeral Home 3021 Eastern Ave., Baltimore, MD 21224				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Vascular Disease</u> Due to (or as a consequence of): b. <u>Advanced Age</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Moderate Dehydration, Decubitus ulcers</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D01464		29d. Date signed (Month, Day, Year) 5-6-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT LIBERTO, MD 3508 Bank St 21224									
31. Date filed (Month, Day, Year) MAY 06 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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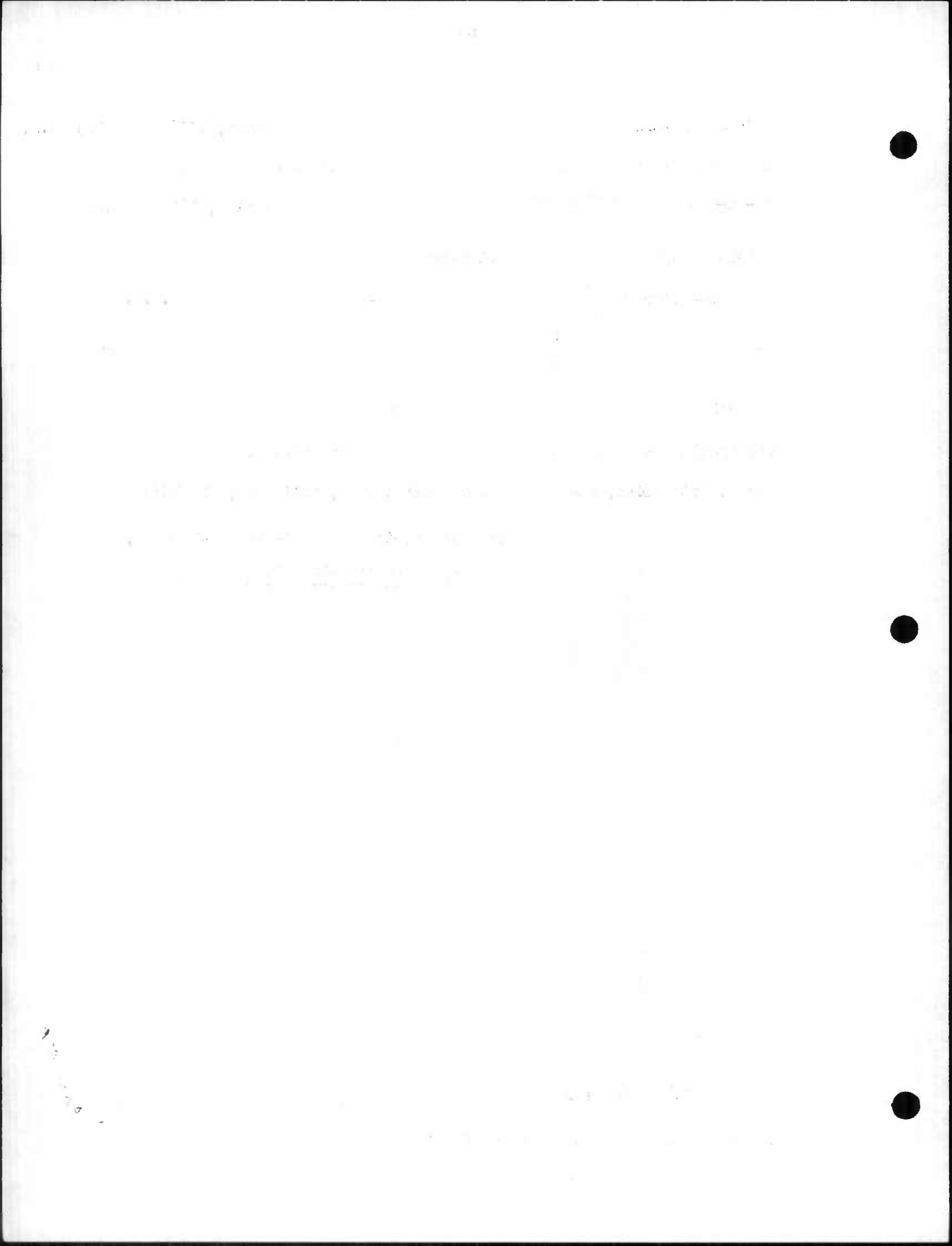
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 13292

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Geneva Kelly</i>				2. DATE OF DEATH MONTH <i>5</i> DAY <i>2</i> YEAR <i>96</i>		3. TIME OF DEATH <i>1920</i> M	
4. SOCIAL SECURITY NUMBER <i>568-10-5388</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12 01 15</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Deaton Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>NA</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>NA</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>611 S. Charles Street</i>				10f. ZIP CODE <i>21230</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNK</i> College (1-4 or 5+) <i>NA</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Never worked</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Disable</i>	
17. FATHER'S NAME (First, Middle, Last) <i>UNK</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>UNK</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Gussie Louelle</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>861 Park Ave Baltimore, MD</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Mt. Zion</i>		20c. DATE <i>5-4-96</i>		20d. LOCATION — City or Town, State <i>Lansdowne, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Albert P. Wylie 74 PA</i> <i>638 N. Gihner ST</i> <i>21217</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute urinary tract infection</i>				Approximate Interval Between Onset and Death <i>1 wk</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Congestive heart failure</i>				<i>Yrs</i>	
		c. <i>Hepatic encephalopathy</i>				<i>Yrs</i>	
		d. <i>Seizure disorder</i>				<i>Yrs.</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>CP Melita, MD</i>				29c. LICENSE NUMBER <i>D34974</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/3/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>5865 Robert Oliver place, #121, Columbia, MD 21045</i>							
31. DATE FILED (Month, Day, Year) <i>5-3-96</i>		32. REGISTRAR'S SIGNATURE <i>MAY 06 1996</i> <i>Lelia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of appendices.

6. The sixth part is a list of figures and tables.

7. The seventh part is a list of abbreviations and symbols.

8. The eighth part is a list of acknowledgments.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of references.

11. The eleventh part is a list of appendices.

12. The twelfth part is a list of figures and tables.

13. The thirteenth part is a list of abbreviations and symbols.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13293

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John E. Klugh, Sr.				2. Date of Death Month Day Year May 2, 1996				3. Time of Death 6:50PM		
	4a. Facility Name (If not institution, give street and number) Stella Maris at Mercy Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-52-7556		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) May 17, 1948		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. Street and Number 5904 Kavon Ave.				10f. Zip Code 21206				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2yrs				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Officer				16b. Kind of Business/Industry Rite Aid Corporation			
17. Father's Name (First, Middle, Last) James L. Klugh						18. Mother's Name (First, Middle, Maiden Surname) Catherine Hess					
19a. Informant's Name/Relationship (Type, Print) Mrs. M. Elaine Klugh						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Kavon Ave. Baltimore, Md. 21206					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		Date 5/6		20c. Location - City or Town, State Baltimore, Md.			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Hartley Miller Funeral Home 7527 Harford Rd. Baltimore, Md. 21234					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. PANCREATIC CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate interval Between Onset and Death ~ 16 mos	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number D40480				29d. Date signed (Month, Day, Year) MAY 6, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRO MD 5810 BELAIR RD BALTO, MD 21206											
31. Date filed (Month, Day, Year) MAY 06 1996											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

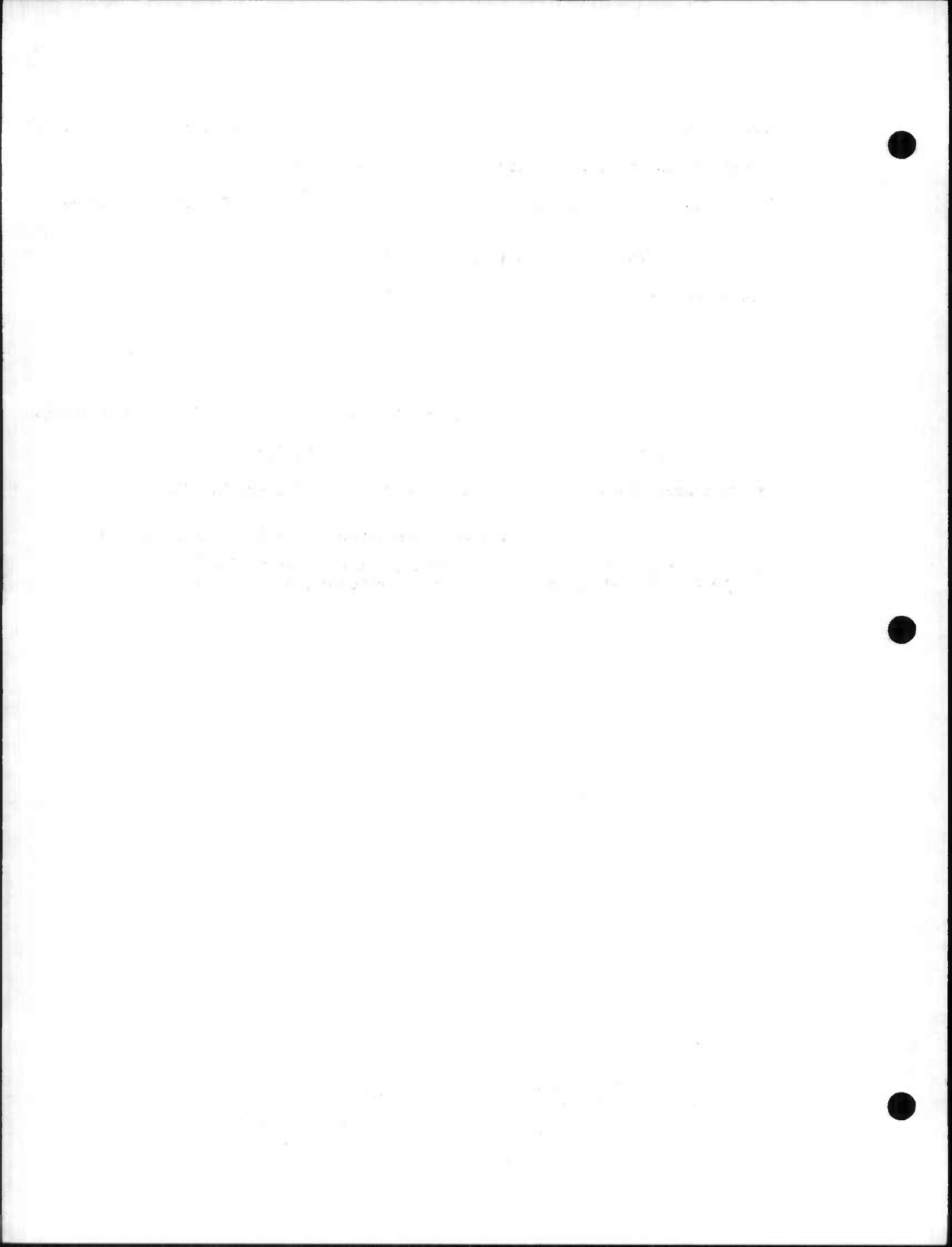
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13294

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA Marie KADLUBOWSKI

2. Date of Death  
Month Day Year

MAY 02 1996

3. Time of Death

7:30 pm

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

215-05-1691

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

8. Data of Birth (Month, Day, Year)

June 06, 1917

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Timonium

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

205 Belmont Forest Court Unit 107

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

08

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anthony Wodalo

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Unknown

19a. Informant's Name/Relationship (Type, Print)

Mr. Melvin F. Kadlubowski (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Belmont Forest Court Unit 107 Timonium, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park

Date

5/06/96

20c. Location - City or Town, State

Baltimore Co. Md.

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT MELANOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Beatriz P. Dizon, M.D.

29c. License number

D16492

29d. Date signed (Month, Day, Year)

May 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEATRIZ P. DIZON, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia T. ...

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 13295

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNE F. KAHN</b>			2. Date of Death Month Day Year <b>APRIL 27, 1996</b>			3. Time of Death <b>7:30 A.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>			4c. County of Death <b>N/A</b>				
Funeral Director	5. Social Security Number <b>215-32-4638</b>			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 22, 1908</b>			
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number <b>1190 W. NORTHERN PARKWAY, APT. 219</b>			10f. Zip Code <b>21210</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATOR</b>			16b. Kind of Business/Industry <b>BOARD OF ELECTIONS</b>				
	17. Father's Name (First, Middle, Last) <b>SOLOMON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CECELIA MARYLISS</b>			19a. Informant's Name/Relationship (Type, Print) <b>MRS. SAUNDRA KRIEGER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 PINE SPRINGS LANE OWINGS MILLS, MD 21117</b>	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP - 4-29-1996 BALTIMORE, MD</b>			20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee <i>Jay Lewis</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Leukemia - acute myelocytic</b>			Approximate Interval Between Onset and Death <b>1 month</b>	
Physician /Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aortic stenosis</b> <b>Stroke</b> <b>Hypertension</b>			23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Sydney Morris</i>			29c. License number <b>N2600</b>			29d. Date signed (Month, Day, Year) <b>4/27/1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SYDNEY MORRIS, M.D. TOWER 110 JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND</b>			31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>			32. Registrar's Signature <i>W. Davidson-Randall</i>				



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**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13296

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>JOSEPH G. KOST</b>				2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>3:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien - Frankford Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>279-10-1548</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 5, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1303 Dundalk Ave.</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesperson</b>		16b. Kind of Business/Industry <b>Retail Sales</b>			
	17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey E. Odin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1603 E. Branch Ct., Forest Hill, MD 21050</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. Location - City or Town, State <b>5/3/96 Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): c. <b>Renal Failure</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>years</b> <b>years</b> <b>years</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>28d. Describe how Injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D22645</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FREDRICK SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD, 21222</b>		31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13297

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LORETTA MAFFEI LIGHT				2. DATE OF DEATH MONTH DAY YEAR May 1, 1996		3. TIME OF DEATH 1:47P M	
4. SOCIAL SECURITY NUMBER 188-16-1098		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 6, 1922	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. CITY, TOWN OR LOCATION OF DEATH Baltimore		10. COUNTY OF DEATH N/A	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6225 York Road	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Automobile	
17. FATHER'S NAME (First, Middle, Last) Charles Maffei				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helena Edith Bloombaum			
19a. INFORMANT'S NAME (Type/Print) Helena Light Hadley Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1973 Long Corner Road Mt. Airy, Maryland 21771			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Dir. <i>Ronald S. Wade</i>				22. NAME AND ADDRESS OF FACILITY Anatomy Board of Maryland 655 West Baltimore Street Baltimore, Maryland 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>atherosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Pulmonary embolus</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 5 years 1 day							PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic Breast Carcinoma</i>
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Daniel M.D.</i>				29c. LICENSE NUMBER D 37280		29d. DATE SIGNED (Month, Day, Year) 5/2/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 LOCH RAVEN BLVD BALT. MD. 21239							
31. DATE FILED (Month, Day, Year) MAY 06 1996				32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13298

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN GLENN LUCAS</b>			2. Date of Death Month Day Year <b>MAY 02, 1996</b>		3. Time of Death <b>0252AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>6400 BLOCK HOLABIRD AVENUE</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death			
Funeral Director	5. Social Security Number <b>213-82-2008</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1962</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3220 Wallford Drive</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b>			College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Automotive</b>		
17. Father's Name (First, Middle, Last) <b>Ernest Anthony Lucas, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Nellie Harcarik</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Irene N. Findley</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3220 Wallford Drive Dundalk, Maryland 21222</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Memorial Gdns</b>		Date <b>05/06/96</b>		20c. Location - City or Town, State <b>Middle River, Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Multiple Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>5/2/96</b>		28b. Time of Injury <b>2 45 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>motor vehicle collision</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6400 Holobird Ave Baltimore, Md</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 02, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13299

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Miriam B. Levin</u>				2. Date of Death Month <u>April</u> Day <u>29</u> Year <u>1996</u>		3. Time of Death <u>8:00 PM</u>		
	4a. Facility Name (If not institution, give street and number) <u>GENESIS ELDER CARE</u>				4b. City, Town, or Location of Death <u>RANDALLSTOWN</u>		4c. County of Death <u>BALTIMORE</u>		
Funeral Director	5. Social Security Number <u>217-03-1787</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>SEPT. 19, 1913</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
	10a. State <u>MARYLAND</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>RANDALLSTOWN</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <u>9109 LIBERTY ROAD</u>				10f. Zip Code <u>21133</u>		10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>PROPERTY OFFICER</u>		16b. Kind of Business/Industry <u>U.S. GOVERNMENT</u>		
	17. Father's Name (First, Middle, Last) <u>ABRAHAM BLOCK</u>				18. Mother's Name (First, Middle, Maiden Summa) <u>SARAH ABRAM</u>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>MRS. HELEN GOLDBERG (SISTER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3304 LEE COURT BALTIMORE, MD 21208</u>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>BNAI ISRAEL -</u>		Data <u>5-2-1996</u>		20c. Location - City or Town, State <u>BALTIMORE, MD</u>		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>SOL LEVINSON &amp; BROS., INC.</u> <u>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</u>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>CENTRAL NERVOUS SYSTEM DEGENERATION YRS</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Kenneth M. Zonies</u>		29c. License number <u>020333</u>		29d. Date signed (Month, Day, Year) <u>4/30/96</u>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>1777 REISTERSTOWN RD PIKEVILLE MD 21208</u>								
State Registrar	31. Date filed (Month, Day, Year) <u>MAY 06 1996</u>				32. Registrar's Signature <u>[Signature]</u>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13300

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY LAVINE</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>				3. Time of Death <b>7:48PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>184-20-0528</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 10, 1929</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>ELLICOTT CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3422 FORT HILL DRIVE</b>				10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRESIDENT</b>			16b. Kind of Business/Industry <b>D &amp; H DISTRIBUTORS</b>		
	17. Father's Name (First, Middle, Last) <b>ISRAEL LEVINE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA LUCKMAN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. MERRILL LAVINE (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7209 ROLLINGWOOD DRIVE CHEVY CHASE, MD 20815</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OHEV SHALOM</b>		Date <b>5-2-1996</b>		20c. Location - City or Town, State <b>WILLIAMSPORT, PA</b>			
	21. Signature of Funeral Service Licensee <i>Michael B...</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ELECTRICAL MECHANICAL DISSOCIATION</b> Due to (or as a consequence of): b. <b>SEPSIS</b> Due to (or as a consequence of): c. <b>metastatic colon cancer</b> Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>non-insulin dependent diabetes mellitus, aortic stenosis, hypertension, subacute bacterial endocarditis</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Julia C. Tchou M.D.</i>		29c. License number <b>N0031</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JULIA C. TCHOU JOHNS HOPKINS HOSPITAL</b>										
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <i>Julia Davidson-Rendell</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

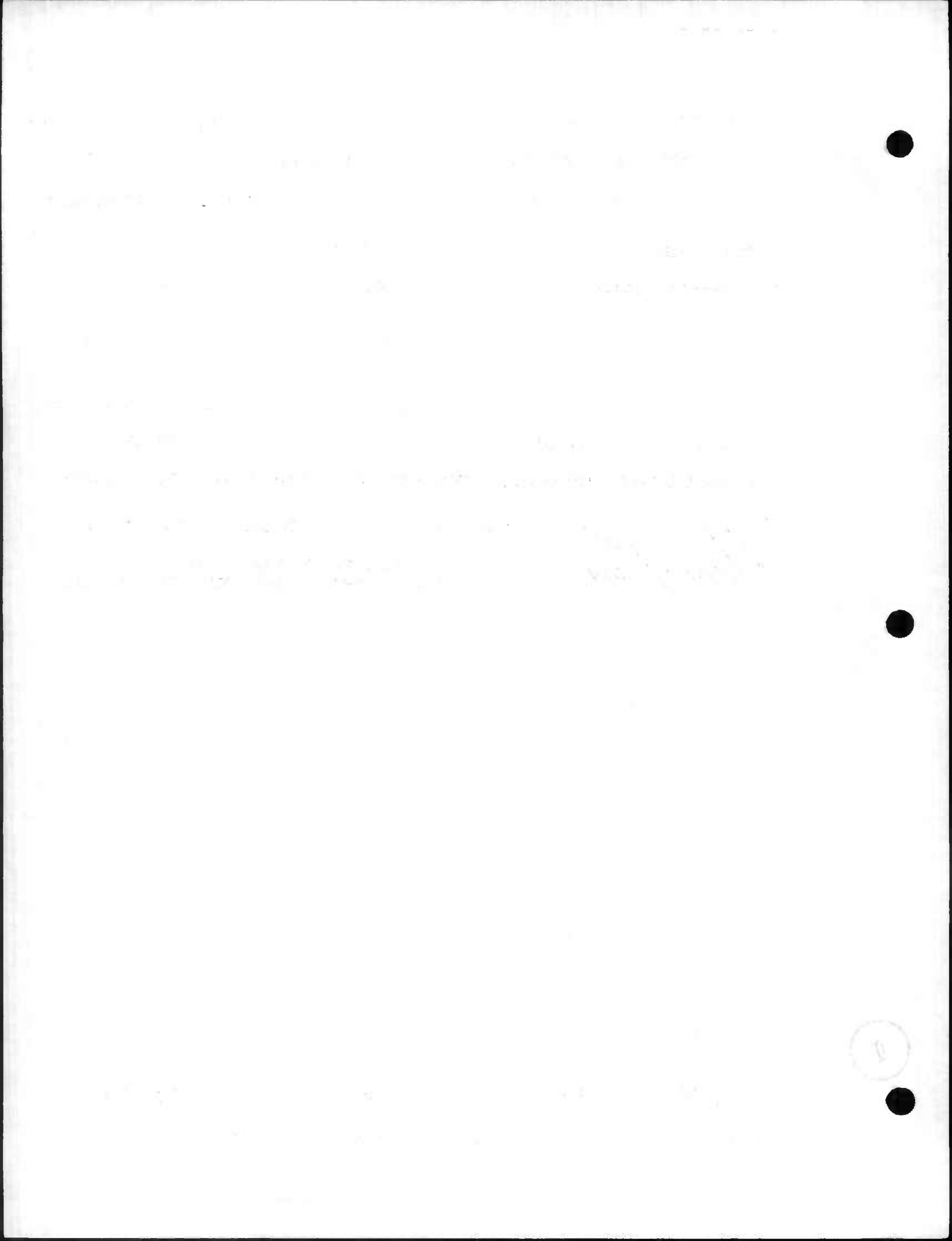
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13301

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John James Linardi</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MAY 03 1996</i>		3. TIME OF DEATH <i>4:55 P M</i>	
4. SOCIAL SECURITY NUMBER <i>219-18-1398</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 21, 1922</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Keswick Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>700 W. 40th Street</i>			
10f. ZIP CODE <i>21211</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Shoe Repair</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Self Employed</i>			
17. FATHER'S NAME (First, Middle, Last) <i>James Linardi</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Grace Vicchio</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Jim J. Linardi, Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>501 W. University Pkwy Apt 2E Baltimore, Maryland 21210</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest VA Cemetery 5/7/96</i>		20c. LOCATION — City or Town, State <i>Owings Mills, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i>				22. NAME AND ADDRESS OF FACILITY <i>A. Alan Seitz, Jr. Funeral Home Baltimore, Maryland 21211</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASCD</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>CAD</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Embolic CVA</i> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>A-fib, CHF</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David G. Roberts, M.D.</i>				29c. LICENSE NUMBER <i>D34988</i>		29d. DATE SIGNED (Month, Day, Year) <i>5-4-96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David G. Roberts, M.D. 10755 Falls Rd, Suite 460, Lutherville, Md. 21093</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 06 1996</i>				32. REGISTRAR'S SIGNATURE <i>David G. Roberts</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6+1





96-2337-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13302

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DWAYNE FRAZIER MORRIS		2. Date of Death Month Day Year APRIL 29, 1996		3. Time of Death 8:26PM
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 219-84-6691	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	8. Date of Birth (Month, Day, Year) May 8, 1973	9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md	10b. County Howard	10c. City, Town or Location Columbia		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 12126 Little Patuxent Pkwy		10f. Zip Code 21044		10g. Citizen of What Country? U.S.A
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never worked		16b. Kind of Business/Industry N/A
	17. Father's Name (First, Middle, Last) Frazier B. Morris		18. Mother's Name (First, Middle, Maiden Surname) Donna Queen		
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donna Queen - mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12126 Little Patuxent Pkwy Columbia, Md 21044		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk		20c. Location - City or Town, State Arbutus, md
	21. Signature of Funeral Service Licensee Sally March		22. Name and Address of Facility March F. H - west 4300 Wabash Ave		
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year) 4-29-96					
28b. Time of Injury 1:53 PM					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred Motorcyclist in accident					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET					
28f. Location (Street and Number or Rural Route Number, City or Town, State) Brokenland Pkwy + Gibson RD					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29c. Signature and title of certifier Kara Lake MD					
29d. License number O.C.M.E.					
29e. Date signed (Month, Day, Year) APRIL 30, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAY 06 1996					
32. Registrar's Signature J. Davidson-Rendell					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 13303

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Meekins, SR.</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MAY 1, 1996</i>		3. TIME OF DEATH <i>1:45A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-36-1237</i>		5. SEX <i>1 M 2 F</i>		6. AGE (In yrs. last birthday) <i>54</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan 28, 1942</i>	
8. FACILITY NAME (If not institution, give street and number) <i>JOSEPH RICHIE HOUSE</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>BALTO.</i>		10. COUNTY OF DEATH <i>NA</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md</i>		10b. COUNTY <i>NA</i>		10c. CITY, TOWN OR LOCATION <i>Balto</i>		10d. INSIDE CITY LIMITS? <i>1 X YES 2 NO</i>	
10e. STREET AND NUMBER <i>643 N. Augusta Ave</i>				10f. ZIP CODE <i>21229</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) <i>NA</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SANITATION ENGINEER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Balto. City Waste Dept</i>			
17. FATHER'S NAME (First, Middle, Last) <i>CLARENCE MEKINS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>BETTEL WATERS</i>			
19a. INFORMANT'S NAME (Type/Print) <i>BETTEL LAMAR</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>643 N. Augusta Ave - Balto. Md 21229</i>					
20a. METHOD OF DISPOSITION <i>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK 5-7-96</i>		20c. LOCATION — City or Town, State <i>RANDALLSTOWN Md</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thymus B. Harris</i>		22. NAME AND ADDRESS OF FACILITY <i>MARCH FUNERAL HOME - West 4300 Wabash Ave. Balto Md 21215</i>					
23. PART I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARCINOMA OF THE LIVER</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 X NO</i>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 X NO</i>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i>		26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE</i>					
27. MANNER OF DEATH <i>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <i>1 YES 2 NO</i>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Gormley MD</i>				29c. LICENSE NUMBER <i>D18587</i>		29d. DATE SIGNED (Month, Day, Year) <i>MAY 1 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul Gormley 900 CATON AVE BALTO. MD 21229</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 06 1996</i>		32. REGISTRAR'S SIGNATURE <i>Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

541



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13304

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine MONROE</b>				2. Date of Death Month <b>April</b> Day <b>26</b> , Year <b>1996</b>				3. Time of Death <b>11:15 pm</b>										
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore County</b>										
Funeral Director	5. Social Security Number <b>213-20-0402</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/17/08</b>		9. Birthplace (State or Foreign Country) <b>unknown</b>											
	Usual Residence of Decedent																		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>1046 Old North Point Road</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A</b>													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> Collage (1-4or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>			16b. Kind of Business/Industry <b>unknown</b>												
17. Father's Name (First, Middle, Last) <b>unknown</b>					18. Mother's Name (First, Middle, Maiden Sumama) <b>unknown</b>														
19a. Informant's Name/Relationship (Type, Print) <b>unknown</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>														
20e. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomy Board</b>			Date <b>4/29/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>											
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Dir.</i>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Pulmonary Embolism</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>1/2 Hour</b></td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Deep Vein Thrombosis</b> Due to (or as a consequence of):</td> <td><b>5 Days</b></td> </tr> <tr> <td>c. <b>Possible Pancreatic Malignancy</b> Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>Pulmonary Embolism</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1/2 Hour</b>	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Deep Vein Thrombosis</b> Due to (or as a consequence of):	<b>5 Days</b>	c. <b>Possible Pancreatic Malignancy</b> Due to (or as a consequence of):		d.	
Immediate Cause (Final disease or condition resulting in death)	a. <b>Pulmonary Embolism</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1/2 Hour</b>																	
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Deep Vein Thrombosis</b> Due to (or as a consequence of):	<b>5 Days</b>																	
	c. <b>Possible Pancreatic Malignancy</b> Due to (or as a consequence of):																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fracture Humerus, Malnutrition secondary to retro-peritoneal mass, diet controlled diabetes, chronic anaemia</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred										
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>Shallin M.D.</i>				29c. License number <b>RD1916</b>			29d. Date signed (Month, Day, Year) <b>April 26, 1996</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mimi Khin M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237</b>																			
31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>			32. Registrar's Signature <i>Randall</i>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13305

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bobette Moore Jane Moore</i>		2. Date of Death Month <i>4</i> Day <i>30</i> Year <i>96</i>		3. Time of Death <i>4:15 pm</i>
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>203-20-5531</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>68</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>10-23-1927</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		
Usual Residence of Decedent					
10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Dundalk</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>1737 Manor Road</i>			10f. Zip Code <i>21222</i>		10g. Citizen of What Country? <i>United States</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 years</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Registered Nurse</i>		16b. Kind of Business/Industry <i>Healthcare</i>	
17. Father's Name (First, Middle, Last) <i>Torence Miller</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Mae Lutz</i>		
19a. Informant's Name/Relationship (Type, Print) <i>David S. Moore</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2806 Bay Drive Baltimore, Maryland 21219</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holly Hill Memorial Gdns</i>		20c. Location - City or Town, State <i>5/3/96 Middle River, Maryland</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Md. 21222</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>CVA</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <i>~7d</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Jennifer R. Farrell MD</i>		29c. License number <i>94014</i>		29d. Date signed (Month, Day, Year) <i>4/30/96</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Jennifer Farrell 4940 Eastern Ave Baltimore, MD 21224</i>					
31. Date filed (Month, Day, Year) <i>MAY 06 1996</i>		32. Registrar's Signature <i>Gina Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





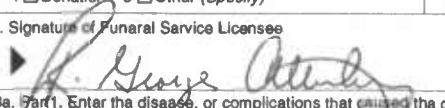
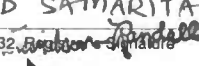
**Division of Vital Records, P.O. Box 68760,**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13307  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARILYNN Patricia MEYERS</b>				2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>10:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL,</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-26-4711</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 18, 1929</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>5915 Theodore Ave.</b>				10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Operator</b>			16b. Kind of Business/Industry <b>Social Security</b>	
	17. Father's Name (First, Middle, Last) <b>Clyde Charles Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Marguerite Hain</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Frederick Meyers</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5915 Theodore Ave., Baltimore, MD 21214</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Data <b>5/4/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>SEPTIC SHOCK.</b> Due to (or as a consequence of): b. <b>RUPTURED SIGMOID DIVERTICULUM WITH DIVERTICULITIS</b> Due to (or as a consequence of): c. <b>DIVERTICULITIS.</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 4 days 10 days.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADENOCARCINOMA LUNG (Stage III) s/p RADIOTHERAPY</b> <b>DIABETES MELLITUS.</b> <b>COPD.</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>PO 9307</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>UMA RANI, GOOD SAMARITAN HOSPITAL, BALTIMORE</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13308

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLOIS MARTIN</b>						2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>6:57 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3021 ROSALIND AVE.</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-363339</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR 1, 1940</b>		9. Birthplace (State or Foreign Country) <b>GEORGIA</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3021 ROSALIND AVE.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>ASBESTOS</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HENRY TATE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>IDA JAMES</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>LOUISE L. MARTIN</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3021 ROSALIND AVE. BALT. MD. 21215</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION</b>		20c. Location - City or Town, State <b>5/4/96 LANGDON MD.</b>		20d. Location - City or Town, State <b>270 FREDRICKSON PASS BALT. MD. 21229</b>				
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>GARY F. MARCH FUNERAL HOME P.A.</b> <b>270 FREDRICKSON PASS BALT. MD. 21229</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Gastric Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>029071</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. KRISHNAN MD 821 N. EVANS ST # 305 BALTIMORE MD 21201</b>											
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13309

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MEYER OKOPOV</b>				2. Date of Death Month <b>April</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>7:20AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital 2401 Belvedere Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-35-7461</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC. 29, 1912</b>	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3615 FORDS LANE, APT. 213</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE MAN</b>		16b. Kind of Business/Industry <b>SHOE FACTORY</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>SHOMON OKOPOV</b>				18. Mother's Name (First, Middle, Maiden Sumame) <b>PEARL FARBER</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. LINA KALANTYRSKAYA (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4000 GLENGYLE AVE., APT. C BALTIMORE, MD 21215</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON-CHIZUK AMUNO</b>		20c. Location - City or Town, State <b>4-29-1996- BALTIMORE, MD</b>		20d. Date		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Respiratory Failure</b> Due to (or as a consequence of): <b>b. Aspiration</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Clara B. Herrin MD</b>		29c. License number <b>AS2402321CH9001</b>		29d. Date signed (Month, Day, Year) <b>April 27, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Clara Herrin Sinai Hospital, Baltimore MD</b>									
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

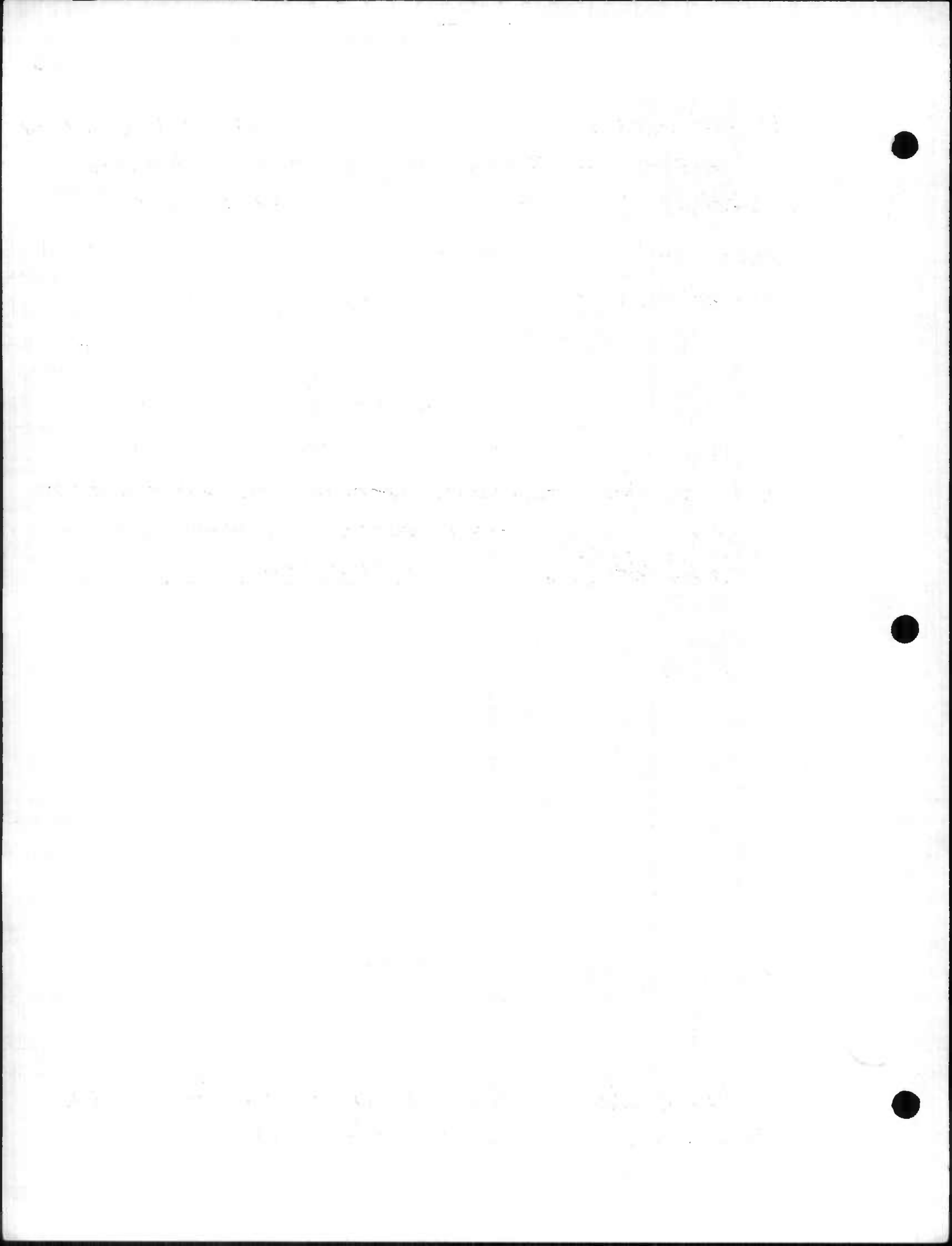
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13310

Item: 16a, per F.H. G-735 5/9/96 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAMON PLEASANT		2. Date of Death Month Day Year APRIL 27, 1996		3. Time of Death 1156 AM
	4a. Facility Name (If not institution, give street and number) 2120 NORTH SMALLWOOD STREET		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-84-2977	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct 21, 1970		9. Birthplace (State or Foreign Country) Md		
Usual Residence of Decedent					
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2120 N. Smallwood Street			10f. Zip Code 21216		10g. Citizen of What Country? U S A
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <del>Never worked</del> Unemployed			16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) Willie Robinson			18. Mother's Name (First, Middle, Maiden Surname) Gladys C. Pleasant		
19a. Informant's Name/Relationship (Type, Print) Gladys C. Pleasant-Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 N. Smallwood Street Baltimore, Md 21216		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition King Memorial Park ARBUTUS MEMORIAL PK 5496		20c. Location - City or Town, State Randallstown, MD <del>ARBUTUS MD</del>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 4-27-96		28b. Time of Injury 1150 M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2120 Smallwood St.			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 28, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. ARONLOCKE, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13311

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES QUINN</b>				2. Date of Death Month <b>APR</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>14:30</b>			
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>			
Funeral Director	5. Social Security Number <b>214-14-7602</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 05, 1918</b>	9. Birthplace (State or Foreign Country) <b>unknown</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>526 S. Chapelgate Lane</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>unknown</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Scott Hilleary/Caregiver</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>		22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hemorrhagic Infarct - right parietal lobe</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>3 days</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia; Seizure disorder</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>William A. [Signature] MD Resident Physician</b>		29c. License number <b>D-44789</b>		29d. Date signed (Month, Day, Year) <b>APR 23 1996</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ST AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD 21229</b>				31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>				32. Registrar's Signature <b>[Signature]</b>	

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

unlabeled

State room.

Wade, Dir.

State  
Baltimore

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS W. QUINN JR.			2. Date of Death Month Day Year APRIL 16 1996		3. Time of Death 4:55 P.M.		
	4a. Facility Name (If not institution, give street and number) 6301 HOLLY LANE APT F			4b. City, Town, or Location of Death N/A		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 105-38-3185		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 30, 1946	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) QUEENS N.Y.					
To Be Completed by Funeral Director	10a. State MD.	10b. County BALTIMORE	10c. City, Town or Location N/A			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6301 HOLLY LANE			10f. Zip Code 21212		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry EDUCATION			
	17. Father's Name (First, Middle, Last) THOMAS W. QUINN SR.			18. Mother's Name (First, Middle, Maiden Surname) MARY C. LANDAU				
	19a. Informant's Name/Relationship (Type, Print) MARY C. QUINN			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 MINTON LANE FAIR HAVEN, N.J. 07704				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CEM.		Data 4/20/96	20c. Location - City or Town, State MIDDLETOWN N.J.		
	21. Signature of Funeral Service Licensee Thomas J. Skarda Jr.			22. Name and Address of Facility SKARDA F.H. 5829 HUDSON ST. BALTIMORE, MD. 21224				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 4-16-96		28b. Time of Injury FOUND AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: HOME		28d. Describe how injury occurred UNKNOWN				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 17, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

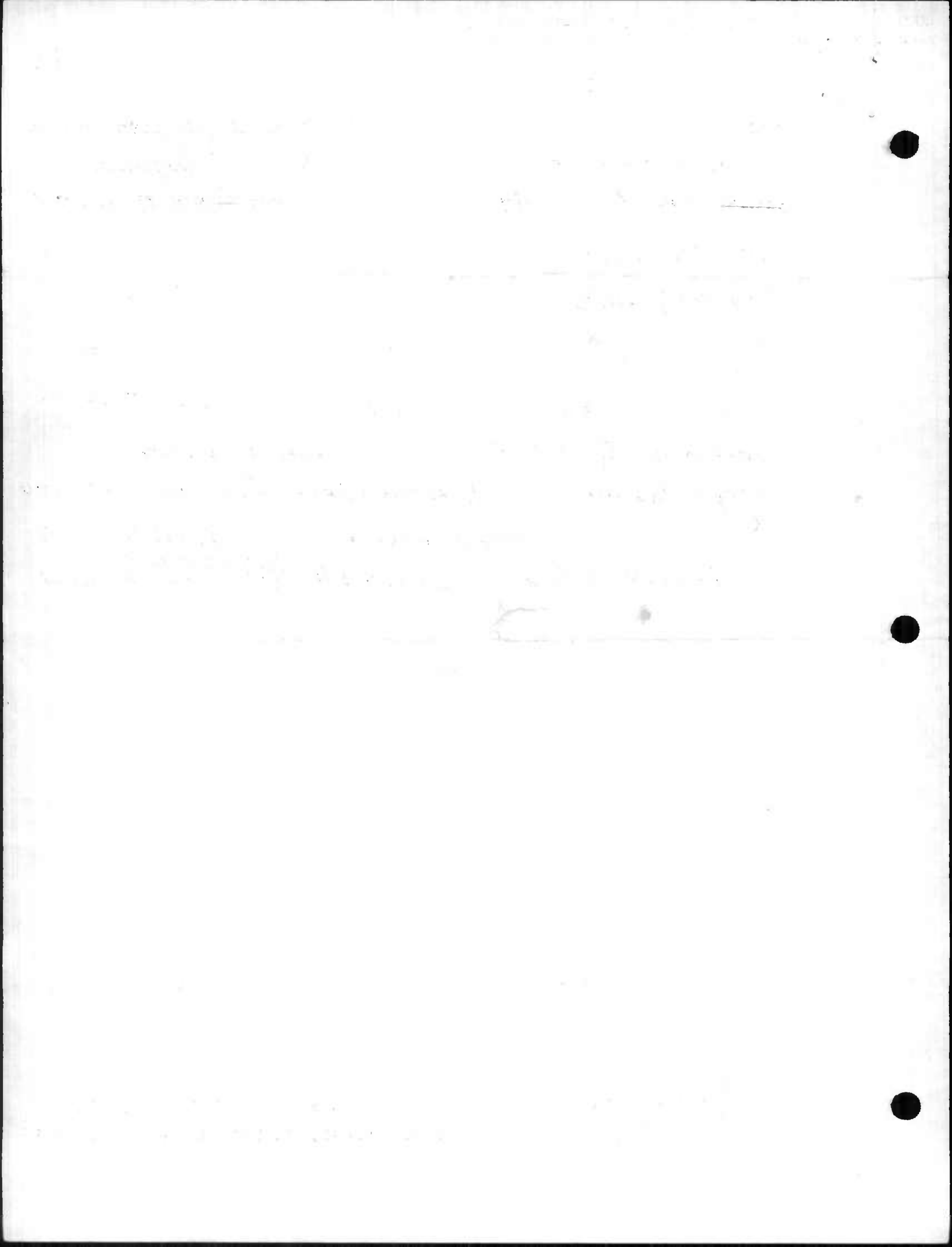
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13313

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Velma L. Robinson</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>				3. Time of Death <b>11:11 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>819 Richwood Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-30-4063</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 4 1935</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <b>819 Richwood Ave</b>				10f. Zip Code <b>21212</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2 yrs</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>				16b. Kind of Business/Industry <b>Postal Service</b>		
17. Father's Name (First, Middle, Last) <b>Thomas Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Harvey</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Michael Meads - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>819 Richwood Ave. Balto md. 21212</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Deird Ridge Cem.</b>		20c. Location - City or Town, State <b>5-7-96 Balto. Md</b>				
21. Signature of Funeral Service Licensee <b>Glynis B Harris</b>				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue, Baltimore, MD 21215</b>						
23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PROBABLE SEPSIS</b> <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b> <b>DIABETES MELLITUS 14 YR</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John A. Neill MD</b>		29c. License number <b>D14623</b>		29d. Date signed (Month, Day, Year) <b>5-3-96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. 526 200 E. 33RD ST. BALT., MD. 21218</b>										
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>										
32. Registrar's Signature <b>Julia Davidson-Randall</b>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of differential equations.

2. In the second part, we consider the case of a linear differential equation. It is shown that the problem can be solved by the method of variation of constants.

3. In the third part, we consider the case of a nonlinear differential equation. It is shown that the problem can be solved by the method of perturbation.

4. In the fourth part, we consider the case of a system of differential equations. It is shown that the problem can be solved by the method of matrix.

5. In the fifth part, we consider the case of a partial differential equation. It is shown that the problem can be solved by the method of separation of variables.

6. In the sixth part, we consider the case of a boundary value problem. It is shown that the problem can be solved by the method of Green's function.

7. In the seventh part, we consider the case of an initial value problem. It is shown that the problem can be solved by the method of Laplace transform.

8. In the eighth part, we consider the case of a problem of stability. It is shown that the problem can be solved by the method of Lyapunov.



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State of Maryland / Department of Health and Mental Hygiene

96 13314

item #17 film g735 5/13/93ag per FH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CALVIN N. ROGERS, II.</b>		2. Date of Death Month <b>4</b> Day <b>1996</b> Year		3. Time of Death <b>21:16 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>8600 QUAD AVE.</b>		4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>220-88-6585</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>19 Yrs.</b>	If Under 1 Year Months <b>19</b> Days <b>19</b>	If Under 24 Hrs. Hours <b>19</b> Min. <b>19</b>
	8. Date of Birth (Month, Day, Year) <b>Dec. 7, 1976</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>677 S. Avondale Rd.</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>Unemployed</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>N/A</b>
17. Father's Name (First, Middle, Last) <del>Calvin Crawley, Sr.</del> <b>CALVIN N. ROGERS SR.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lolita Crawley</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lolita Crawley</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>677 S. Avondale Rd. Balto., MD 21222</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Pk.</b>		Date <b>5/8</b>	20c. Location - City or Town, State <b>Randallstown, MD</b>
21. Signature of Funeral Service Licensee <i>James A. Morton</i>			22. Name and Address of Facility <b>James A. Morton &amp; Sons Funeral Home 1701 Laurens St. Balto. MD 21217</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Multiple Injuries</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-4-96</b>		28b. Time of Injury <b>2:05 PM</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>motorcycle collision</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8600 Quad Ave. Baltimore, Md</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.					
29b. Signature and title of certifier <i>Dennis J. Chute</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 5, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <i>Lola Jackson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13315

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harriette Sheldon Rugh

2. Date of Death

Month  
MayDay  
4Year  
1996

3. Time of Death

2:40 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Brightwood

4b. City, Town, or Location of Death

Brooklandville

4c. County of Death

Baltimore

5. Social Security Number

082-22-5466

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 24, 1904

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

700 West Melrose Avenue

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Independent Preschool

17. Father's Name (First, Middle, Last)

Edward Martin Sheldon

18. Mother's Name (First, Middle, Maiden Surname)

Annie Armstrong

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Rugh Downs/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

700 West Melrose Ave., Baltimore, MD 21210

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

05/04/96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

John J. Edwards

29c. License number

D34952

29d. Date signed (Month, Day, Year)

May 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Thomas Evelius, M.D. 5444 BELAIR ROAD BALTIMORE MARYLAND 21206

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

John Davidson-Rondelle

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13316

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>FRIEDERIKE RHEINHEIMER</b>					2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>9:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
<b>Funeral Director</b>	5. Social Security Number <b>214-56-9976</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 22, 1949</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Union Bridge</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>Linden House at Johnsville 10929 Green Valley Road</b>					10f. Zip Code <b>21791-8411</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>			16b. Kind of Business/Industry <b>Disabled</b>			
17. Father's Name (First, Middle, Last) <b>Walter Heinrich Rheinheimer</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Eloise Hurt</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Walter Heinrich Rheinheimer/father</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Linden House at Johnsville 10929 Green Valley Road, Union Bridge, MD 21791-8411</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 05/04/96</b>			20c. Location - City or Town, State <b>Baltimore, MD</b>				
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b> 					22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> YEARS <b>7</b></p> <p>b. <b>UROSEPSIS</b> DAYS <b>7</b></p> <p>c. _____</p> <p>d. _____</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARANOID SCHIZOPHRENIA</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>K.S. RAO, M.D.</b>		29c. License number <b>043462</b>		29d. Date signed (Month, Day, Year) <b>MAY 3 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K.S. RAO, M.D., NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD</b>										
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13317

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div style="text-align: center;">CAROLYN E ROBINSON</div>					2. Date of Death Month Day Year MAY 2, 1996		3. Time of Death 9:10am			
	4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE			
<b>Funeral Director</b>	5. Social Security Number 214-203108		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 1, 1927		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MARYLAND			10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4218 FALLSTAFF RD.					10f. Zip Code 21215			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			18b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) MENASHA					18. Mother's Name (First, Middle, Maiden Surname) FANNIE FISHER						
19a. Informant's Name/Relationship (Type, Print) MRS. MARLEEN SOLLOD (SISTER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4203 COLONIAL RD. BALTIMORE, MD 21208						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO		Date 5-3-1996		20c. Location - City or Town, State BALTIMORE, MD			
21. Signature of Funeral Service Licensee <i>Joel D Lewis</i>					22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Metastatic Breast Cancer</u> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death <u>one year</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>John H. Copeland MD</i>					29c. License number D27034			29d. Date signed (Month, Day, Year) May 2, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Hank Copeland 5310 Old Court Road suite 201 Randallstown MD 21133											
31. Date filed (Month, Day, Year) MAY 06 1996					32. Registrar's Signature <i>Julia Jackson-Bond</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

The Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 13318

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTHER REICH</b>				2. Date of Death Month Day Year <b>APRIL 29 1996</b>		3. Time of Death <b>7:50am</b>		
	4a. Facility Name (If not institution, give street and number) <b>CHERRYWOOD MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>REISTERSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>214-40-2650</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 6, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>POLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent									
10a. State <b>MD</b>			10b. County <b>BALTIMORE</b>			10c. City, Town or Location <b>BALTIMORE</b>			
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number <b>7014 ALDEN RD.</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>			
16b. Kind of Business/Industry <b>BALTIMORE CITY</b>			17. Father's Name (First, Middle, Last) <b>CHARLES MILLER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>RACHAEL UNKNOWN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MRS. BARBARA WELLINGTON (DAUG.)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>766 KENNINGTON RD. REISTERSTOWN, MD 21136</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from Site 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH EL MEM. PARK</b>			20c. Location - City or Town, State <b>5/1/96 RANDALLSTOWN, MD</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral vascular accident</b> <b>Protein calorie malnutrition</b> <b>Multiple decubiti</b>									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how Injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <b>D. Roggen MD</b>			29c. License number <b>D 35844</b>			29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. Roggen 1777 Reisterstown Rd Suite 108 W Baltimore MD 21208</b>									
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>			32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



96-2351-033

ITEMS: 23PART I, 27, PER MED FILM G-736 6/14/96 t.t

B.K.S ITEM: 9. PER F.H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FILM G-735 5/28/96 t.t

State of Maryland / Department of Health and Mental Hygiene

96 13319

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TIMOTHY ROBINSON</b>		2. Date of Death Month Day Year <b>APRIL 30, 1996</b>		3. Time of Death <b>0110 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>GREATER LAUREL HOSPITAL</b>		4b. City, Town, or Location of Death <b>LAUREL</b>		4c. County of Death <b>PRINCE GEORGES</b>
Funeral Director	5. Social Security Number <b>227-25-1574</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>14</b> Yrs.	8. Date of Birth Month Day Year <b>JUN. 29, 1981</b>	9. Birthplace (State or Foreign) <b>FORT BELVOIR, VA</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>P.G. Co.</b>	10c. City, Town or Location <b>LAUREL</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>9072 MANORWOOD RD.</b>		10f. Zip Code <b>20723-1390</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT</b>		16b. Kind of Business/Industry <b>EDUCATION</b>
	17. Father's Name (First, Middle, Last) <b>DONALD ROBINSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>THERESA SHIRODA</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DONALD ROBINSON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9072 MANORWOOD RD. LAUREL MD. 20723</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOUNTAINVIEW CEM.</b>	Date	20c. Location - City or Town, State <b>SOUTH RANGE MI.</b>	
	21. Signature of Funeral Service Licensee <b>Thomas J. Skarda</b>		22. Name and Address of Facility <b>SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA DUE TO CONGENITAL ABNORMALITY OF THE CONDUCTION SYSTEM OF THE HEART</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Keynote One Goule</b>		29c. License number <b>O.C.M.E</b>	29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYAMON D. KOSKUN 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Judi Shuckor-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13320

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN ROGERS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>02</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0600 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>327-46-5963</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 19, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Fairhaven</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Sykesville</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Sykesville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7200 Third Ave. C-29</b>	
10f. ZIP CODE <b>21784</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>+2</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered nurse</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Medical/Health care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward W. Kress</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma E. Ruff</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dr. William Rogers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6305 Boxwood Rd. Baltimore, MD 21212</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium, City or Town, State, Zip Code) <b>Oakland Cemetery, Warren PA 5/7</b>			
20c. LOCATION — City or Town, State <b>Warren, PA</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harry W. Hight</b>			
22. NAME AND ADDRESS OF FACILITY <b>Haight Funeral Home P.O. Box 195 Sykesville MD 21784</b>				23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>MINS.</b>  <b>YRS.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>MAY 02 1996</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Philip Neil Phelps MD, MED. EXAMINER</b>				29c. LICENSE NUMBER <b>D36908</b>			
29d. DATE SIGNED (Month, Day, Year) <b>2/MAY/96</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>11722 REISTERSTOWN RD. REISTERSTOWN MD 21136</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13321

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OTTO ANTONIO SILVA</b>				2. Date of Death Month <b>MAY</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>12:30A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>4610 NORFOLK AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212 26 3933</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT 29, 1931</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>4610 NORFOLK AVENUE</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S. OF A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b>		College (1-4 or 5+) <b>none</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>official machanist union official</b>		16b. Kind of Business/Industry <b>MANUFACTURING</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>ANTONIO PAUL SILVA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SUSIE STEWART</b>			
	19a. Informant's Name/Relationship (Type, Print) (WIFE) <b>MRS. MARY DELORES SILVA</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4610 NORFOLK AVENUE BALTO., MD. 21216</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		Date <b>MAY 9, 1996</b>		20c. Location - City or Town, State <b>BALTO. BALTIMORE, MD. CO.</b>	
	21. Signature of Funeral Service Licensed <b>LEWIS T. GWYNN</b> <i>Lewis T. Gwynn</i>				22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 3 YEARS Due to (or as a consequence of): b. <b>MULTIPLE BRAIN INFARCTIONS</b> Due to (or as a consequence of): c. <b>DIABETES MELLITUS TYPE II</b> Due to (or as a consequence of): d. <b>HYPERTENSION ESSENTIAL</b>							Approximate interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Raynold Depestre MD</i>		29c. License number <b>D 27157</b>		
				29d. Date signed (Month, Day, Year) <b>MAY, 6, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAYNOLD DEPESTRE 3100 TIMANUS LA BALTIMORE MD. 21244</b>								
31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>				32. Registrar's Signature <i>Jana Davidson-Randall</i>				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13322

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE R. SLOANE</b>				2. Date of Death Month <b>5</b> Day <b>3</b> Year <b>96</b>		3. Time of Death <b>11:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Church Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216 012 276</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 20, 1912</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Md.</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>503 S. Durham Street</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Rigger</b>			16b. Kind of Business/Industry <b>Steel</b>	
17. Father's Name (First, Middle, Last) <b>John Sloane</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Loehr</b>				
19e. Informant's Name/Relationship (Type, Print) <b>John G. Hemmeter, cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5698 Utrecht Road, Baltimore, Md. 21206</b>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>5-6-96</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>
21. Signature of Funeral Service Licensee <b>Ann J. Hadden</b>				22. Name and Address of Facility <b>Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis, Metabolic Acidosis, Cardio Pulmonary</b> Due to (or as a consequence of): <b>b. Chronic Dementia, Decubitus Ulcers</b> Due to (or as a consequence of): <b>c. </b> Due to (or as a consequence of): <b>d. </b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Dementia, Decubitus Ulcers</b> <b>Chronic Vegetative State</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-3-96</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Sunil Ahuja</b>				29c. License number <b>D28762</b>		29d. Date signed (Month, Day, Year) <b>5-5-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SUNIL AHUJA 100 N. BROADWAY, BALTIMORE, MD 21231</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>Julia Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13323

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Stokes, Jr</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>12:51 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Md General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-42-9746</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 3, 1944</b>	
	9. Birthplace (State or Foreign Country) <b>Md</b>		10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1100 Bolton Street</b>				10f. Zip Code		10g. Citizen of What Country? <b>U S A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Trash Man</b>		16b. Kind of Business/Industry <b>City of Baltimore Sanitation</b>			
	17. Father's Name (First, Middle, Last) <b>George R. Stokes, Sr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Green</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Shyree Jefferson- Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4964 Edgemere Avenue Baltimore, Md 21215</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>5696 Catonsville, Md</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>					
	23a. Part I. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. <b>Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of): <b>Pulmonary Hypertention</b> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Chronic Respiratory Insufficiency</b> Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>89205</b>		29d. Date signed (Month, Day, Year) <b>May 4, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. David Ho C/O Maryland General Hospital 827 Linden Avenue</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13324

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN H. SULLIVAN				2. Date of Death Month Day Year MAY 03 1996		3. Time of Death 4:05 pm		
	4a. Facility Name (If not institution, give street and number) IVY HALL NURSING HOME				4b. City, Town, or Location of Death ESSEX MARYLAND		4c. County of Death BALTIMORE MD.		
Funeral Director	5. Social Security Number 216-09-2050		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) SEPT 25, 1920		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE MARYLAND		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 218 NORTH PORT STREET		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) 2YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC		16b. Kind of Business/Industry FREIGHT CO.					
17. Father's Name (First, Middle, Last) GILBERT SULLIVAN				18. Mother's Name (First, Middle, Maiden Surname) MARY SCHMIDT					
19a. Informant's Name/Relationship (Type, Print) BERTHA M. SULLIVAN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 NORTH PORT STREET BALTIMORE MARYLAND 21224					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM.		20c. Date 5/7		20d. Location - City or Town, State BALTIMORE MARYLAND			
21. Signature of Funeral Service Licensee <i>Hartley Miller</i>				22. Name and Address of Facility HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MARYLAND 21234					
23a. Pertinent Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. MULTIPLE DECUBITUS ULCER Due to (or as a consequence of): c. DIABETES - OUT OF CONTROL Due to (or as a consequence of): d. PERIPHERAL VASCULAR DISEASE Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA HYPERTENSION CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>D. Harrison</i> M.D.		29c. License number D 31464		29d. Date signed (Month, Day, Year) 5/6/96					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHOALB A. HASHTMI, 121 BACK RIVER NECK RD, BALTIMORE MD 21224									
31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature <i>Harrison-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10


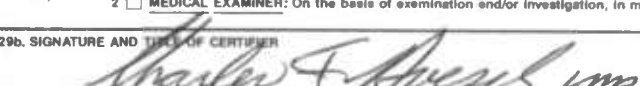

State  
Registrar



96 13325

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDERICK X STURM, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 2, 1996</b>		3. TIME OF DEATH <b>8:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-09-5662</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 3, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>8405 Macer Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lutherville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Lutherville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8405 Macer Rd.</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW-II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lieutenant Colonel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Army</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Frederick X Sturm, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Tynan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eileen M. Sturm</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8405 Macer Rd. Lutherville, Md. 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Veterans 5/6/96</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF LUNG</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>3 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>CHARLES F. HOESCH, M.D.</b>				29c. LICENSE NUMBER <b>020390</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHARLES F. HOESCH, M.D. 9712 BEANE RD, BACTO MD 21236</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13326

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael J

2. Date of Death

May 03 1996

3. Time of Death

10:09pm

4a. Facility Name (If not institution, give street and number)

Belair Nursing &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Belair

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

216 09 9121

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 20, 1907

9. Birthplace (State or Foreign Country)

Baltimore, Md

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1 Colgate Drive

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Butcher

16b. Kind of Business/Industry

Food Store

17. Father's Name (First, Middle, Last)

John Andrew Saffa

18. Mother's Name (First, Middle, Maiden Surname)

Antonnia Kostelska

19a. Informant's Name/Relationship (Type, Print)

Mary Kulisiewicz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44 Roycroft Lane Delta, Pennsylvania 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

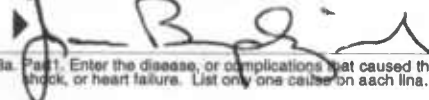
Lake View Cemetery 5/7/1996

Data

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Eastern Ave. Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease - Uremia.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Nephropathy.

Due to (or as a consequence of):

ten years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

435522

29d. Date signed (Month, Day, Year)

May 4, 1996.

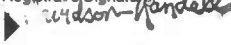
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Wild 2 North Avenue Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13327

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOWARD SIEBERT</b>		2. Date of Death Month <b>MAY</b> Day <b>2nd</b> Year <b>1996</b>		3. Time of Death <b>7:58AM</b>
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>144-26-7145</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 9, 1933</b>		9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RANDALLSTOWN</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>8635 LUCERNE RD.</b>			10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1955-57</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES REPRESENTATIVE</b>		16b. Kind of Business/Industry <b>ZEP MANUFACTURING</b>	
17. Father's Name (First, Middle, Last) <b>LOUIS SIEBERT</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>CHARLOTTE WASSER</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MRS. JOAN SIEBERT (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8635 LUCERNE RD. RANDALLSTOWN, MD 21133</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERTOWN RD. BALTO., MD 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LIVER CARCINOMA</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS TYPE I</b>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D 27157</b>		29d. Date signed (Month, Day, Year) <b>MAY 2nd 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER</b>					
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13328

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Harrison Shorter

2. Date of Death

April 26 1996

3. Time of Death

4:50 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Simi Hospital 2401 Belvidere Ave

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

212-07-3734

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July-12-1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

none

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

308 N. Monastery Street

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Afr American

To Be Completed by Funeral Director

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waiter

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

William H. Shorter

18. Mother's Name (First, Middle, Maiden Surname)

Helen Rebecca Shorter

19a. Informant's Name/Relationship (Type, Print)

Karlener Shorter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1230 W. Lafayette Ave Baltimore, Maryland 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus memorial

Date

5/1/96

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

Henry M. Chelmer

22. Name and Address of Facility

Wallace Funeral Service  
3405 W. Franklin Street  
Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fatal injury. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Anemia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Valeri Sen

29c. License number

AS 2402321VS9931

29d. Date signed (Month, Day, Year)

April 26 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 Belvidere Ave Baltimore MD

31. Date filed (Month, Day, Year)

MAY 06 1996

Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13329

Item: 1, per F.H. G-735 5/6/96 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RONALD DUANE DWAYNE STAAB</b>		2. Date of Death Month Day Year <b>MAY 02, 1996</b>		3. Time of Death <b>0252AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>6400 BLOCK HOLABIRD AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-84-2474</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Nov 1, 1961</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>N/A</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>1930 Robinwood Rd</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cement finisher</b>		16b. Kind of Business/Industry <b>Baltimore County</b>	
	17. Father's Name (First, Middle, Last) <b>Robert R. Staab</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Benetta J. Fullwood</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Robert R. Staab / father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1930 Robinwood Rd Baltimore, Md 21222</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill</b>		20c. Location - City or Town, State <b>5/6/96 Baltimore, Md</b>	
21. Signature of Funeral Service Licensee <i>Anthony Colt Connelly</i>		22. Name and Address of Facility <b>Connely Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>				
Physician /Medical Examiner	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>5/2/96</b>		28b. Time of Injury <b>2:45 AM</b>	
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <b>motor vehicle collision</b>			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6400 Blk Holabird Ave Baltimore, Md</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dennis J. Chute</i>		29c. License number <b>O.C.M.E.</b>		
29d. Date signed (Month, Day, Year) <b>MAY 02, 1996</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <i>Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13330

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose Evelyn Suttles				2. Date of Death Month Day Year May 2 1996		3. Time of Death 6:00 PM	
	4e. Facility Name (If not institution, give street and number) 49 Loring Ct.				4b. City, Town, or Location of Death N/A		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 226-26-5958		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 9, 1926	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Md		10b. County Baltimore		10c. City, Town or Location N/A			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 49 Loring Ct.				10f. Zip Code 21219		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Food	
17. Father's Name (First, Middle, Last) Walter F. Barbour				18. Mother's Name (First, Middle, Maiden Surname) Elsie M. Durham				
19a. Informant's Name/Relationship (Type, Print) Carolyn Vitek / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Loring Ct. Baltimore, Md 21219				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 5/3/96		20c. Location - City or Town, State Catonsville, Md		
21. Signature of Funeral Service Licensee Anthony Colt Connelly				22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. ischemic heart disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Peripheral vascular disease GI Bleed						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Catherine Washburn MD		29c. License number DA1982		29d. Date signed (Month, Day, Year) 5-3-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Washburn, M.D. 1005 North Point Rd Baltimore, Md 21224								
31. Date filed (Month, Day, Year) MAY 06 1996				32. Registrar's Signature Julia Davidson-Rendell				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13331

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cecelia Elizabeth Thoms</b>				2. Date of Death Month <b>May</b> Day <b>05</b> Year <b>1996</b>		3. Time of Death <b>10:25 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Dulaney Towson Nursing Home</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore Co.</b>	
Funeral Director	5. Social Security Number <b>216-18-9444</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 22, 1922</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Md.</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>111 West Road</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Receptionist</b>		16b. Kind of Business/Industry <b>Baker Watts</b>		
17. Father's Name (First, Middle, Last) <b>Nicholas Hock</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Wunner</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. George Hock (Brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>918 Shelley Road Towson, Maryland 21286</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gar. 5/8/96</b>		20c. Location - City or Town, State <b>Timonium, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair</b>				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>1. Senile Dementia of the Alzheimer's Type</b> Due to (or as a consequence of): <b>2. AS</b> Due to (or as a consequence of): <b>3. AS</b> Due to (or as a consequence of): <b>4. AS</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
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28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
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State of Maryland / Department of Health and Mental Hygiene

96 13332

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOLLY Clarice TUBMAN</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>4:03 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CTR</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-46-6024</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 10, 1948</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1904 Monroe Street</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CRIMINAL Investigator</b>			16b. Kind of Business/Industry <b>STATE of Maryland PUBLIC DEFENDERS OFFICE</b>		
	17. Father's Name (First, Middle, Last) <b>JAMES E. LAWSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estella Tuggle</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Estella Lawson, Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1421 Madison Ave Baltimore, Md 21217</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star Cem.</b>		20c. Location - City or Town, State <b>5-3-96 Catonsville, Md</b>			
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>CHATHAM - Harris F.N. 5540 REISTERSTOWN ROAD Baltimore, Maryland 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Atherosclerosis Cardiovascular disease</b>  <b>COMPLICATED BY COCAINE AND NARCOTIC INTOXICATION</b>  <b>c. Due to (or as a consequence of):</b>  <b>d. Due to (or as a consequence of):</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>FOUND 04/29/96</b>		28b. Time of Injury <b>FOUND 3:30 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>UNKNOWN</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1904 N. MONROE ST. BALTIMORE, MARYLAND</b>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E</b>	
	29d. Data signed (Month, Day, Year) <b>APRIL 29, 1996</b>							
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13333

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Thorn JR</i>				2. Date of Death Month <i>April</i> Day <i>26</i> Year <i>96</i>				3. Time of Death <i>219 AM</i>	
	4a. Facility Name (If not Institution, give street and number) <i>Good Samaritan Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>169-30-6343</i>		6. Sex <i>10 M 20 F</i>		7. Age (In yrs. last birthday) <i>57</i> Yrs.		8. Date of Birth <i>Nov. 18, 1938</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <i>Yes</i> <input checked="" type="checkbox"/> <input type="checkbox"/> No	
	10e. Street and Number <i>1634 Northwick Road</i>				10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Social Worker</i>				16b. Kind of Business/Industry <i>WOODBOURNE Center</i>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>William Thorne, Sr</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Fannie Lowe</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Carolyn Thomas, Sister</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3314 Ripple Road Baltimore, Maryland 21244</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Cemetery</i>		20c. Date <i>5/4/96</i>		20d. Location - City or Town, State <i>Baltimore, Maryland</i>			
	21. Signature of Funeral Service Licensee <i>Debra Harris</i>				22. Name and Address of Facility <i>CHD Thorne - Barker's Funeral Home 5340 Reisterstown Road Baltimore, MD 21215</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. <i>cardiac arrest</i>								Immediate	
	Due to (or as a consequence of): b. <i>sickle cell disease</i>								57 years	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. _____ Due to (or as a consequence of): d. _____									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>congestive cardiomyopathy</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stan Walker</i>		29c. License number <i>044944</i>		29d. Date signed (Month, Day, Year) <i>5/29/96</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Unon-memorial Hosp. Baltimore, md 21218</i>									
State Registrar	31. Date filed (Month, Day, Year) <i>MAY 06 1996</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13334

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSE H. TURK				2. Date of Death Month Day Year MAY 1, 1996		3. Time of Death 3:15am		
	4a. Facility Name (If not institution, give street and number) 1300 ST. ALBANS ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217401936		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 25, 1915		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1300 ST. ALBANS ROAD		10f. Zip Code 21208		
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER				16b. Kind of Business/Industry EDUCATION				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) EMANUEL HIMMELFARB				18. Mother's Name (First, Middle, Maiden Surname) IDA GERSTEIN				
	19a. Informant's Name/Relationship (Type, Print) DR. JULIEN H. TURK (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 ST. ALBANS ROAD BALTIMORE, MD 21208				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI		20c. Location - City or Town, State 5-3-1996- OWINGS MILLS, MD		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary artery disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hypertension hypercholesterolemia							Approximate Interval Between Onset and Death yrs.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension hypercholesterolemia							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred NA		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA		28f. Location (Street and Number or Rural Route Number, City or Town, State) NA				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier Joyce K. Burd MD				29c. License number D29920		29d. Date signed (Month, Day, Year) 5/1/96		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOYCE K. BURD, MD 2328 W. JOPPA RD, SUITE 310, TIMONIUM, MD 21093								
	31. Date filed (Month, Day, Year) MAY 06 1996				32. Registrar's Signature <i>[Signature]</i>				

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State of Maryland / Department of Health and Mental Hygiene

96 13335

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard THOMAS JR.		2. Date of Death May 3, 1996		3. Time of Death 12: 04pm
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hosp.		4b. City, Town, or Location of Death ESSEX		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 215-22-6309	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) FEB. 22, 1928		9. Birthplace (State or Foreign Country) PA., PA.		
Usual Residence of Decedent					
10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location DUNDALK	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 801 JAYDEE AVE.		10f. Zip Code 21222		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEELWORKER		18b. Kind of Business/Industry STEEL			
17. Father's Name (First, Middle, Last) HOWARD THOMAS JR.		18. Mother's Name (First, Middle, Maiden Surname) EVELYN HILKER			
19a. Informant's Name/Relationship (Type, Print) SHIRLEY ANN THOMAS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 JAYDEE AVE. BALTIMORE, MD. 21222			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State BALTIMORE, MD.	
21. Signature of Funeral Service licensee Thomas J. Akanda Jr.		22. Name and Address of Facility SKARDA F.H. 8829 HUDSON ST. BALTO., MD. 21224			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Septic Shock Due to (or as a consequence of):  b. Disseminated intravascular coagulation Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 24 hours			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28b. Time of Injury		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Liji Mathew M.D.		29c. License number DS0164		29d. Date signed (Month, Day, Year) 5/3/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Liji Mathew, M.D. 9000 Franklin Square Drive Baltimore MD 21237					
31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13336

Items: 25,27,28a-f per MEO G-746 4/1/97 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KENNETH P. TOMLINSON</b>				2. Date of Death Month <b>May</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>3:17 PM</b>										
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>										
Funeral Director	5. Social Security Number <b>214-48-1995</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4-27-1948</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>6 Bethway Drive</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>U.S.A.</b>										
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>construction</b>			16b. Kind of Business/Industry <b>building</b>											
	17. Father's Name (First, Middle, Last) <b>Essie Ray Tomlinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jesse Mildred Parham</b>												
	19a. Informant's Name/Relationship (Type, Print) <b>Andrew Harris</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Bethway Dr. Sykesville, Md. 21784</b>												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>True Gospel Cemetery</b>		Date <b>5-7-96</b>		20c. Location - City or Town, State <b>Lisbon, Md.</b>										
	21. Signature of Funeral Service Licensee <b>Brian Haight</b>				22. Name and Address of Facility <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Myocardial infarction</b></td> <td>37 hrs.</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of): <b>Status post cardiopulmonary resuscitation</b></td> <td>37 hrs.</td> </tr> <tr> <td>c. <b>COMA</b></td> <td>37 hrs.</td> </tr> <tr> <td>d. Due to (or as a consequence of): <b>Status Post motor vehicle accident</b></td> <td>37 hrs.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Myocardial infarction</b>	37 hrs.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): <b>Status post cardiopulmonary resuscitation</b>	37 hrs.	c. <b>COMA</b>	37 hrs.	d. Due to (or as a consequence of): <b>Status Post motor vehicle accident</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>Myocardial infarction</b>	37 hrs.															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): <b>Status post cardiopulmonary resuscitation</b>	37 hrs.															
	c. <b>COMA</b>	37 hrs.															
	d. Due to (or as a consequence of): <b>Status Post motor vehicle accident</b>	37 hrs.															
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of alcohol use</b> <b>History of asthma.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>5/1/96</b>		28b. Time of Injury <b>11:45 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28d. Describe how injury occurred <b>SUBJECT DRIVER OF AUTO THAT LEFT ROADWAY</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) Howard Co. <b>Gaither Rd. &amp; Sidling Ct.</b>											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Aheda Ali Khan M.D.</b>		29c. License number <b>D43323</b>		29d. Date signed (Month, Day, Year) <b>May, 3 1996</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ABEDA ALI KHAN TWO KNOLL NORTH DRIVE COLUMBIA MD 21045</b>																	
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13337

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NAOMI WILKINS</b>				2. Date of Death Month Day Year <b>APRIL 27 1996</b>		3. Time of Death <b>16:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>213-28-5081</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 2, 1928</b>	9. Birthplace (State or Foreign Country) <b>md</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>	10b. County <b>NIA</b>	10c. City, Town or Location <b>Balto</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2223 Ruskin Ave</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>4yr</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Hospital</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Wm. Arnold Turpin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Gardner</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Bobo - Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>538 Oklahoma Ave N.E. Washington, D.C. 20002</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial PK</b>		Date <b>5/1/96</b>	20c. Location - City or Town, State <b>Randallstown, md</b>		
	21. Signature of Funeral Service Licensee <b>H. Valencia Holland</b>		22. Name and Address of Facility <b>March F.H. West 4300 Wabash Ave Balto. Md #15</b>					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. THYMIC CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>1 MONTH</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how Injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>K.S. RAO M.D.</b>		29c. License number <b>D43462</b>	29d. Date signed (Month, Day, Year) <b>APRIL 27 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Lia Taylor-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

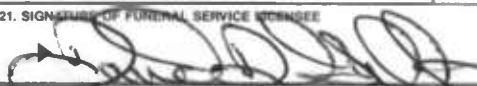
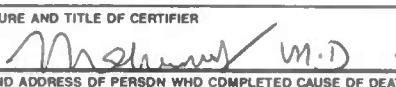
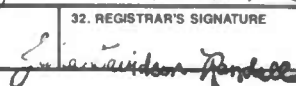




96 13338

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Walborga Friedrich Weikinger</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 02 1996</b>		3. TIME OF DEATH <b>10 15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578-07-8060</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 19, 1898</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>	
9c. COUNTY OF DEATH <b>Harford</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baldwin</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13310 Fork Rd.</b>				10f. ZIP CODE <b>21013</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Seamstress</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pasternak</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Friedrich</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorsch</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Charlotte W. Pine</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13310 Fork Rd. Baldwin, Md. 21013</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Serv. Corp. 5/06/96</b>		20c. LOCATION — City or Town, State <b>Towson, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypervnatremia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>metabolic acidosis</b>				Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>M.D.</b>				29c. LICENSE NUMBER <b>D45921</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 03, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Syed Mahmood, M.D. 15 Old Elm Ct. Lutherville Md. 21093</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13339

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE Augusta WEISS

2. Date of Death

MAY 02, 1996

3. Time of Death

3:11 PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-07-8594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5-9-1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

42 Acorn Circle

10f. Zip Code

21286

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Hans W. Weiss

18. Mother's Name (First, Middle, Maiden Surname)

Helena Mueller

19a. Informant's Name/Relationship (Type, Print)

Marcia Schneider (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8602 Manorfield Road, Perry Hall, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery

Date

5-6-96

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road, Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cardiac arrhythmia due to pulmonary emboli

Hours

Due to (or as a consequence of):

Cancer of cecum

Months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status post right hemicalectomy

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 28982

29d. Date signed (Month, Day, Year)

5/2/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Erlando Romero, M.D. 7620 York Road Towson, Maryland 21204

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended item #1, g-735, 5/6/96eh per fh Amended item #6, 6/12/96emh  
Amended items #4&7, g-736, 6/10/96emh per fh

96 13340

FOR STATE REGISTRAR Item: 23 part I, per M.D. CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES WHITE</b>		2. DATE OF DEATH MONTH <b>April</b> DAY <b>25</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>1549 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220-56-8424</b>		5. SEX <b>M</b>		6. AGE (In yrs. last birthday) <b>53</b> YRS.	
7. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>16</b> YEAR <b>1942</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9. COUNTY OF DEATH <b>N/A</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>YES</b>		10e. STREET AND NUMBER <b>2404 CHARRIS ON BOULEVARD</b>		10f. ZIP CODE <b>21216</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>Never Married</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>NO</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>NO</b>		14. RACE — American Indian, Black, White, etc. <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 years</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private Businesses</b>		17. FATHER'S NAME (First, Middle, Last) <b>JAMES W. WHITE, SR.</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Worine Black</b>		19a. INFORMANT'S NAME (Type/Print) <b>LILLIE DARNAY</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2306 PASTYAN AVE BALTIMORE, MD 21218</b>	
20a. METHOD OF DISPOSITION <b>Burial</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>St. John Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James Harris</b>		22. NAME AND ADDRESS OF FACILITY <b>CHARRIS ON - Harris Funeral Home</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Biventricular Cardiac Failure</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Low Cardiac Output Syndrome</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Aortic and Mitral Regurgitation</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Bacterial Endocarditis</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multorgan Failure, Respiratory</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal, Hepatic</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN</b>	
24a. WAS AN AUTOPSY PERFORMED? <b>NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>NO</b>		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>NO</b>	
26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b>		26. PLACE OF DEATH (Check only one) <b>OTHER:</b>		27. MANNER OF DEATH <b>Natural</b>	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <b>NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>CERTIFYING PHYSICIAN:</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>John A. Walck</b>		29c. LICENSE NUMBER <b>020586</b>	
29d. DATE SIGNED (Month, Day, Year) <b>9/25/96</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John A. Walck</b>		31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>	
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>		33. DATE OF DEATH <b>April 25 1996</b>		34. TIME OF DEATH <b>1549 PM</b>	

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13341

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAULINE WILLIAMS</b>				2. Date of Death Month <b>APRIL</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>7:40 P.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>224-26-8136</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr. 3, 1920</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>710 E. 41st Street</b>			10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aide</b>			16b. Kind of Business/Industry <b>Nursing Home</b>		
	17. Father's Name (First, Middle, Last) <b>PAUL ALSTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pattie Lorraine Evans</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Esther Cherry, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>614 E. 43rd St Baltimore, Md 21212</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>		20d. Date <b>5-4-96</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>CHATHAM - Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>METASTATIC LUNG CANCER</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>6 MONTHS</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PANCREATIC MASS</b> <b>LEUKOCYTOSIS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Walter Puryear, MD</b>		29c. License number <b>M0104</b>		
29d. Date signed (Month, Day, Year) <b>APRIL 30, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WALTER PURYEAR, 110 N. TOWER, JHN, BALTO, MD 21287</b>				
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>[Signature]</b>						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13342

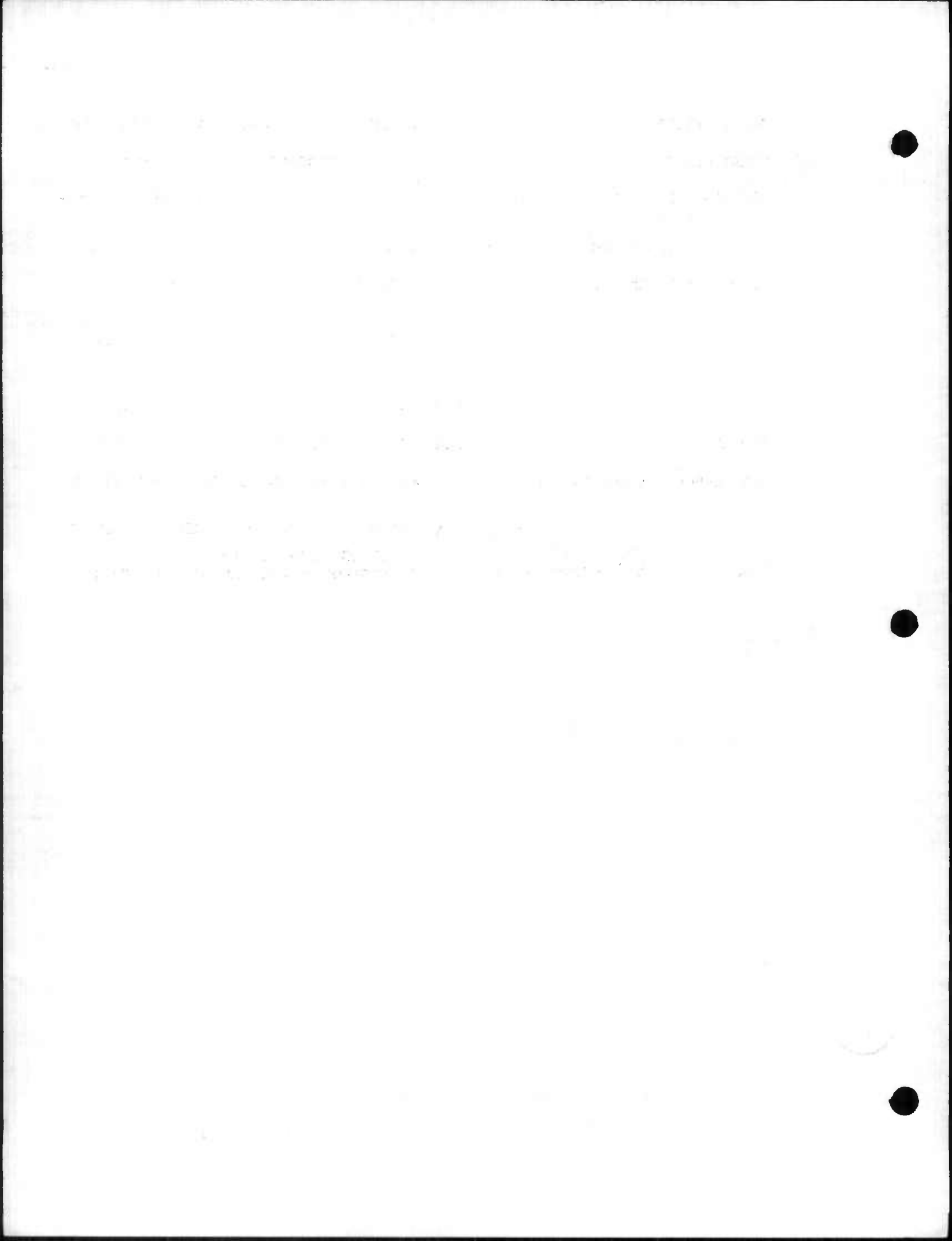
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DR. FREDERICK WILDER				2. Date of Death Month Day Year APR. 29 1996		3. Time of Death 1:33 AM		
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 032-26-2542		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 9, 1930		
	9. Birthplace (State or Foreign Country) NEW YORK								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location OWINGS MILLS			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 9300 TOWN PLACE DR.			10f. Zip Code 21117		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PSYCHIATRIST		16b. Kind of Business/Industry MEDICINE				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) BENJAMIN WEISBERG				18. Mother's Name (First, Middle, Maiden Surname) HENRIETTA KIRSCHNER				
	19a. Informant's Name/Relationship (Type, Print) MRS. CAROLE WILDER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 TOWN PLACE DR. OWINGS MILLS, MD 21117				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		20c. Location - City or Town, State REISTERSTOWN, MD		20d. Date 4/30/96		
	21. Signature of Funeral Service Licensee <i>Joel D Lewis</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>overwhelming sepsis</i> Due to (or as a consequence of): b. <i>unknown</i> Due to (or as a consequence of): c. <i>pneumococcal pneumonia</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 48 hrs 2 wks				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Type II Diabetes mellitus</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ruth S. Horowitz</i>		29c. License number D45811		29d. Date signed (Month, Day, Year) 4/29/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5911 York Rd Baltimore MD 21215									
31. Date filed (Month, Day, Year) MAY 06 1996		32. Registrar's Signature <i>Julia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13343

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Virginia Wilcox</b>				2. Date of Death Month Day Year <b>April 28, 1996</b>		3. Time of Death <b>9:44 pm</b>	
	4e. Facility Name (If not Institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-20-3851</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 12, 1924</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>923 S. CURLEY ST.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMRESS</b>		16b. Kind of Business/Industry <b>CLOTHING</b>		
17. Father's Name (First, Middle, Last) <b>ALBERT URLAHS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH POTENES</b>				
19a. Informant's Name/Relationship (Type, Print) <b>WILLIAM L. WILCOX SR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>923 S. CURLEY ST. BALTIMORE, MD - 21224</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRED HEART OF JESUS</b>		Date <b>MAY 1, 1996</b>		20c. Location - City or Town, State <b>BALTO. CO. MD.</b>		
21. Signature of Funeral Service Licensee <i>Thomas J. Skarda Jr.</i>				22. Name and Address of Facility <b>SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <b>Ischemic bowel</b> Due to (or as a consequence of):								<b>1 month</b>
b. <b>Coronary artery disease</b> Due to (or as a consequence of):								<b>6 years</b>
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Davidson-Randall</i>		29c. License number <b>MS171</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Johns Hopkins Bayview Medical Center</b> <b>2819 New Paul Chowanski</b> <b>4940 Eastern Avenue, Baltimore, MD 21224</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <i>Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

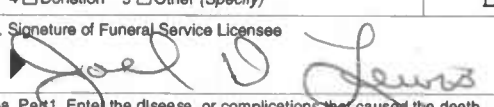
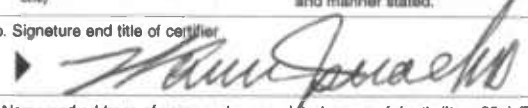
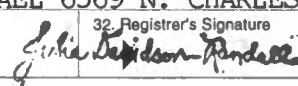
State  
Registrar



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**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13344

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DORA ZABA</b>				2. Date of Death Month Day Year <b>MAY 1, 1996</b>		3. Time of Death <b>6:20pm</b>	
	4e. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>216-62-3184</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1921</b>	9. Birthplace (State or Foreign Country) <b>POLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>3709 BANCROFT RD.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>				
19e. Informant's Name/Relationship (Type, Print) <b>ROBERT BARBER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3709 BANCROFT RD. BALTIMORE, MD 21215</b>				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH TFILOH</b>		20c. Location - City or Town, State <b>5-3-1996- BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Hypotensive Bradycardia</b> Due to (or as a consequence of):</p> <p>b. <b>Atherosclerotic coronary artery Disease</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>40 min</b></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D17803</b>		29d. Date signed (Month, Day, Year) <b>5-2-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. WARREN ISRAEL 6569 N. CHARLES ST., STE 600 TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13345

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sadie ZINN</b>				2. Date of Death Month Day Year <b>April 30, 1996</b>		3. Time of Death <b>5:39 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				4b. City, Town, or Location of Death <b>ESSEX</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-52-3144</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 20, 1908</b>	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>328 S. EAST AVE.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
	17. Father's Name (First, Middle, Last) <b>JOHN McCOTTER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GERTRUDE UNKNOWN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Gloria KOWALEWSKI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>328 S. EAST AVE. BALTIMORE, MD. 21224</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEM.</b>		Date <b>MAY 3 1996</b>	20c. Location - City or Town, State <b>BALTO. CO. MD.</b>		
	21. Signature of Funeral Service Licensee <b>Thomas J. Skarda Jr.</b>				22. Name and Address of Facility <b>HOFFMANN-SKAADA 3218 HUDSON ST. BALTO., MD. 21224</b>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardio Pulmonary Arrest</b> Due to (or as a consequence of): b. <b>Protein Soluble Cardiovascular Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>20 yrs</b>							
	Part II - Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary Embolism &amp; Arterial Boudets</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier <b>Bernard S. Karpas Jr.</b>				29c. License number <b>DO 5917</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, '96</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BERNARD S. KARPAS JR. M.D. 10140 REAO ST. RMD BALTO. MD 21201</b>							
	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>B. Widson-Randell</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13346

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Lillian Adams

2. Date of Death

Month

Day

Year

May 1, 1996

3. Time of Death

7:30pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Physician Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

579-14-2047

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 7, 1922

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Macroom Court

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Floral Designer

16b. Kind of Business/Industry

Florist

17. Father's Name (First, Middle, Last)

George Duvall

18. Mother's Name (First, Middle, Maiden Surname)

Marie Gaylor

19a. Informant's Name/Relationship (Type, Print)

Carol Keesee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Macroom Court, Waldorf, MD 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lakemont Cemetery

Date

5/4/96

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):Approximate  
interval Between  
Onset and Death

hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 27348

29d. Date signed (Month, Day, Year)

5/2/96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Howard Haft, MD 700 Old Line Center, Suite 100, Waldorf, MD 20602

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96-2327-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
 asp ITEMS: 23 PART I, State of Maryland / Department of Health and Mental Hygiene  
 27, 28a-f, PER MEO FILM G-735 5/13/96 t.t

96 13347

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VINCENT ADAMS JR.				2. Date of Death Month Day Year APRIL 30 1996		3. Time of Death 4:21 A	
	4e. Facility Name (If not institution, give street and number) 1133 N. BOND ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-44-9247		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		6. Date of Birth (Month, Day, Year) APR. 10, 1948	
	9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent 10a. State: MARYLAND 10b. County: N/A 10c. City, Town or Location: BALTIMORE CITY 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12TH College (1-4 or 5+): N/A		16. Kind of Business/Industry BALTIMORE CITY	
	17. Father's Name (First, Middle, Last) VINCENT ADAMS, SR.		18. Mother's Name (First, Middle, Maiden Surname) HELEN JONES		19. Informant's Name/Relationship (Type, Print) ANTHONY MARTIN -SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3039 KENYON AVE. BALTO, MD 21213	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEM.		Date MAY 7, 1996		20c. Location - City or Town, State BALTO, MARYLAND	
	21. Signature of Funeral Service Licensed <i>Calvin B. Scruggs, Jr.</i>		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE ALCOHOL INTOXICATION		Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) FOUND 4-30-96		28b. Time of Injury UNKNOWN M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred SUBJECT INGESTED ALCOHOL	
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>J. L. A. Lock</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 30, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. A. Lock, MD		31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature <i>J. L. A. Lock</i>		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES H. BOLDEN</b> <b>James Bolden</b>				2. Date of Death Month <b>April</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>11:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greenspring N/H</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>01 705-12-4370</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 4, 1917</b>	9. Birthplace (State or Foreign Country) <b>Md</b>
	Usual Residence of Decedent							
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5653 Govane Avenue</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>U S A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Roofing</b>		16b. Kind of Business/Industry <b>Roofing</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert Bolden Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5653 Govane Avenue Baltimore, Md 21212</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date <b>5-3-96</b>		20c. Location - City or Town, State <b>Arbutus, Md</b>		
21. Signature of Funeral Service Licensee <b>Sharon Stokes</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Balto, Md 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): <b>a. ASPIRATION PNEUMONIA</b> <b>b. Cerebrovascular Accident</b> <b>c. Hypertension</b> <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of): <b>Many years</b> <b>Many years</b>								Approximate Interval Between Onset and Death <b>2 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dasanthakuma MD</b>		29c. License number <b>D42510</b>		29d. Date signed (Month, Day, Year) <b>04/29/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>John Davidson Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ITEM: 1. PER F.H. FILM G-735 5/7/96 t.t  
FOR  
STATE  
REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

96 13349

1. DECEDENT'S NAME (First, Middle, Last) <b>RAY PRICE BROWN</b>			2. DATE OF DEATH MONTH DAY YEAR <b>May 1 1996</b>			3. TIME OF DEATH <b>10:17 P M</b>																	
4. SOCIAL SECURITY NUMBER <b>283-05-5759</b>			5. SEX <b>1 M 2 F</b>			6. AGE (In yrs. last birthday) <b>84</b> YRS.			7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 10, 1911</b>			8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>											
9a. FACILITY NAME (If not institution, give street and number) <b>Granada Nursing Home</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>						9c. COUNTY OF DEATH <b>N/A</b>											
10a. STATE <b>Maryland</b>						10b. COUNTY <b>N/A</b>						10c. CITY, TOWN OR LOCATION <b>Baltimore</b>						10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>					
10e. STREET AND NUMBER <b>4017 Liberty Hgts. Ave.</b>						10f. ZIP CODE <b>21207</b>						10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>						12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES						13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:						14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>9 Elementary/Secondary (9-12) 0 College (1-4 or 5+)</b>						16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>						16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>											
17. FATHER'S NAME (First, Middle, Last) <b>Ed Brown</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Loving</b>																	
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Louise Davis</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4017 Liberty Hgts. Ave. Balto. Md. 21207</b>																	
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>						20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion</b>						20c. LOCATION — City or Town, State <b>Lansdowne, Md.</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>						22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>																	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Dementia</b> c. <b>Cerebrovascular accident</b> d. <b>Hypertension</b>												Approximate Interval Between Onset and Death <b>5 min to 104-8 5-8 209-8</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>gastroesophageal reflux. Adynamic colon spasticity &amp; contractures seizures</b>												24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>						26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 OOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>																	
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>						28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED											
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>						29b. SIGNATURE AND TITLE OF CERTIFIER <b>John A. Wilkens</b>						29c. LICENSE NUMBER <b>D30494</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/3/96</b>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John A. Wilkens 4500 Wilkens Ave Baltimore MD 21249</b>																							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>						32. REGISTRAR'S SIGNATURE <b>John A. Wilkens</b>																	





96 13350



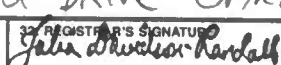
1- FOR  
STATE  
REGISTRAR

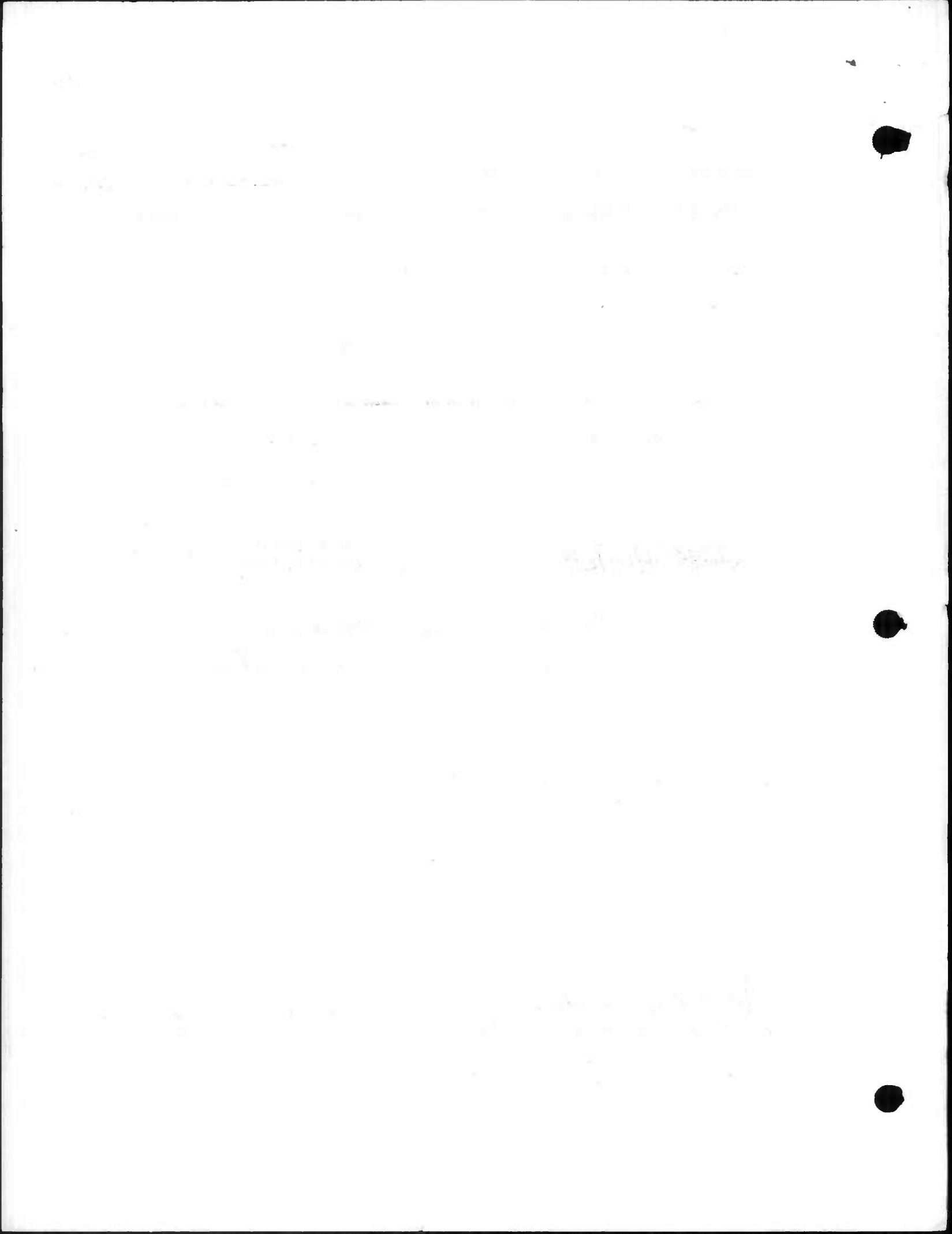
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Richard Kent Bolyard</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>28</b> YEAR <b>96</b>		3. TIME OF DEATH <b>12:30 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214-34-9574</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>66</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>09-07-1929</b>		8. BIRTHPLACE (State or Foreign Country) <b>Aurora, WV</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Cuppett-Weeks Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Oakland</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>706 E. Alder St.</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Raymond Bolyard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alta Teets</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Larry Bolyard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 Cornell St. Keyser, WV 26726</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Aurora Cemetery 4-30</b>		20c. LOCATION — City or Town, State <b>Aurora, WV</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hinkle Funeral Home, Inc. PO Box 186, Davis WV 26260</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>FEVER, etiology undetermined</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Diabetes mellitus with peripheral vasc. disease x4y</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>organic brain syndrome s/p CVA</b> <b>s/p (L) below knee amputation</b>  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30035</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-28-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1533 Memorial Drive OAKLAND MD 21550 J. Richter</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 13351**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Hilda Blaylock

2. Date of Death

Month April Day 29 Year 1996

3. Time of Death

10 35 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

215-22-1613

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

2725 Huntingdon Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Benjamin Franklin Crawford

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Catherine Burke

19a. Informant's Name/Relationship (Type, Print)

Frederick O. Blaylock

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2725 Huntingdon Avenue, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

5/3

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Burgee-Henss Funeral Home 21211  
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Hours

b. Bronchopulmonary Fistula

Due to (or as a consequence of):

Days

c. Emphysema

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Asst. Director  
Dept. Emergency Medicine

29c. License number

D36786

29d. Date signed (Month, Day, Year)

April 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6392 Rainbow Spn, Columbia MD 21045

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13352

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA EDNA BACHMANN				2. Date of Death Month Day Year May 3, 1996		3. Time of Death 6:00 AM		
	4a. Facility Name (If not institution, give street and number) 5212 Ballman Avenue, 21225				4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 214-72-2325		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 9, 1911	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore (Brooklyn Heights)		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5212 Ballman Avenue				10f. Zip Code 21225		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		18b. Kind of Business/Industry Housewife and Mother		
	17. Father's Name (First, Middle, Last) John Nicholas Burmeister				18. Mother's Name (First, Middle, Maiden Surname) Bertha Viola Hiller				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ms. D. Elaine Mooney-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Ballman Ave., Baltimore, Maryland 21225				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date May 6, 1996		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee Kevin E. Ecker				22. Name and Address of Facility McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225-1856				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) e. <u>Acute Coronary Occlusion</u> Due to (or as a consequence of): b. <u>Hypertension</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Paul J. Chang M.D.		29c. License number D09046		29d. Date signed (Month, Day, Year) May 3, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul J. Chang, M.D. 801 Crain Highway, Glen Burnie, Maryland 21061									
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature John Davidson							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13353

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUNE MAY BOSMAN

2. Date of Death

Month  
MAYDay  
2Year  
1996

3. Time of Death

05:50

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

217-12-7411

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 14, 1924

9. Birthplace (State or Foreign Country)

BALTO., MD

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

REHOBETH BEACH

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

48 SPINNING WHEEL LANE

10f. Zip Code

19971

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

NORMAN THORN

18. Mother's Name (First, Middle, Maiden Surname)

CLARA MITCHELL

19a. Informant's Name/Relationship (Type, Print)

SHARON A. GREAVES (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1717 CARROLL AVENUE - HALETHORPE, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VETS CEM

Date

05/06

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Jackie H. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
interval Between  
Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Ann M. Maguire MD

29c. License number

D44303

29d. Date signed (Month, Day, Year)

May 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANN MAGUIRE, MD ST. AGNES HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

John Davidson-Randall

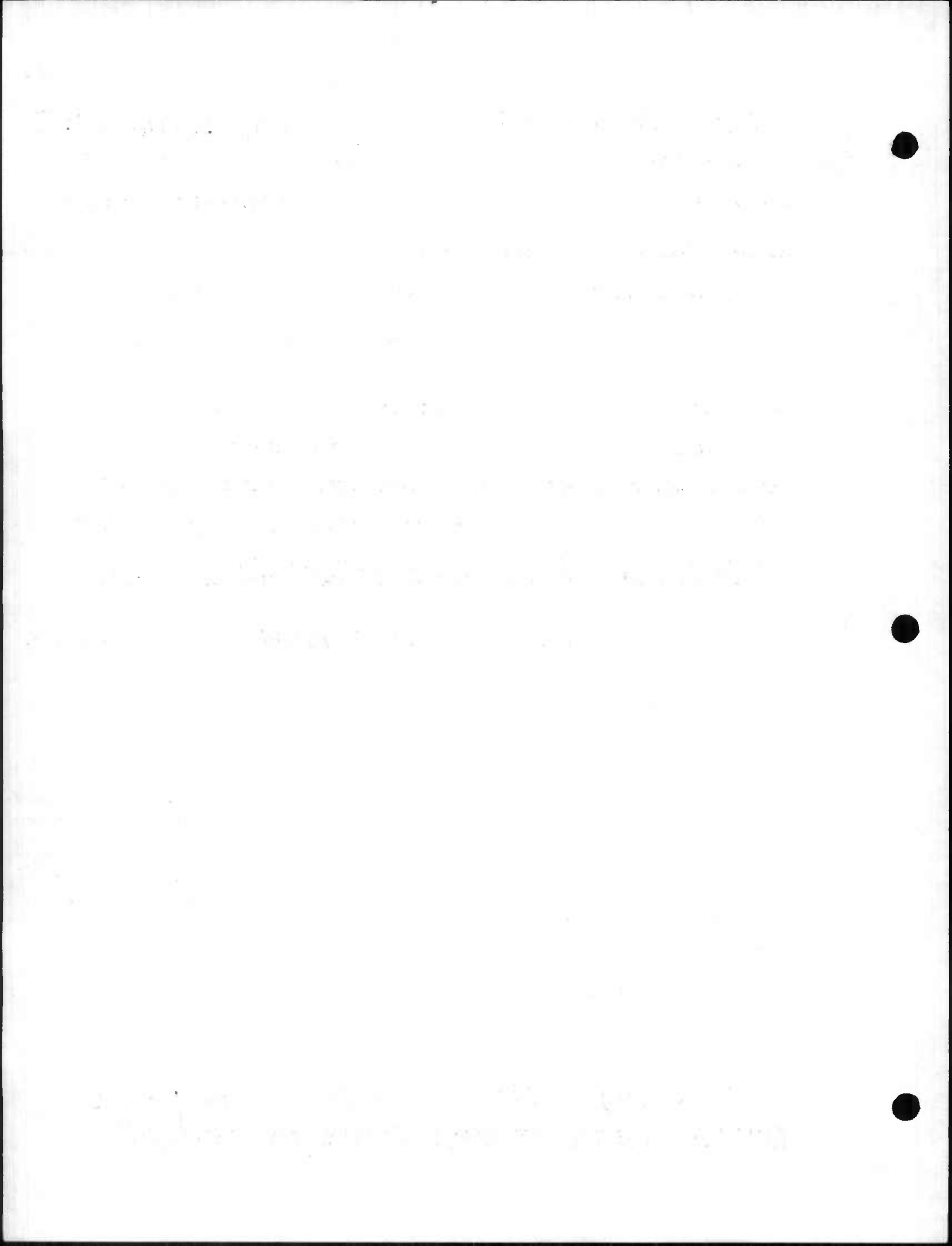
State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELWOOD LEVI BAREHAM</b>				2. Date of Death Month Day Year <b>May 02 1996</b>		3. Time of Death <b>6:05 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>St Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson, Maryland</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-16-5943</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/21/1920</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>COCKEYSVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>212 Sherwood Rd.</b>				10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II DAV 1970</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Black &amp; Decker</b>	
	17. Father's Name (First, Middle, Last) <b>Harvey Howard Bareham</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Virginia Nailor</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Betty J. Bareham</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>212 Sherwood Rd., Cockeysville, MD 21030</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion U.Meth.Church</b>		Date <b>6 MAY</b>		20c. Location - City or Town, State <b>UPPERCO Cockeysville, MD</b>	
	21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic Renal Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	Approximate Interval Between Onset and Death <b>1 1/2 yrs</b>							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary emphysema</b> <b>Diabetes Mellitus</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Natividad D. de Leon, M.D.</b>				29c. License number <b>D19508</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Natividad D. de Leon M.D. St Joseph Medical Center, Towson, Maryland</b>							
	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b> 32. Registrar's Signature <b>John Anderson-Rodall</b>							

Baltimore, Maryland 21215-0020

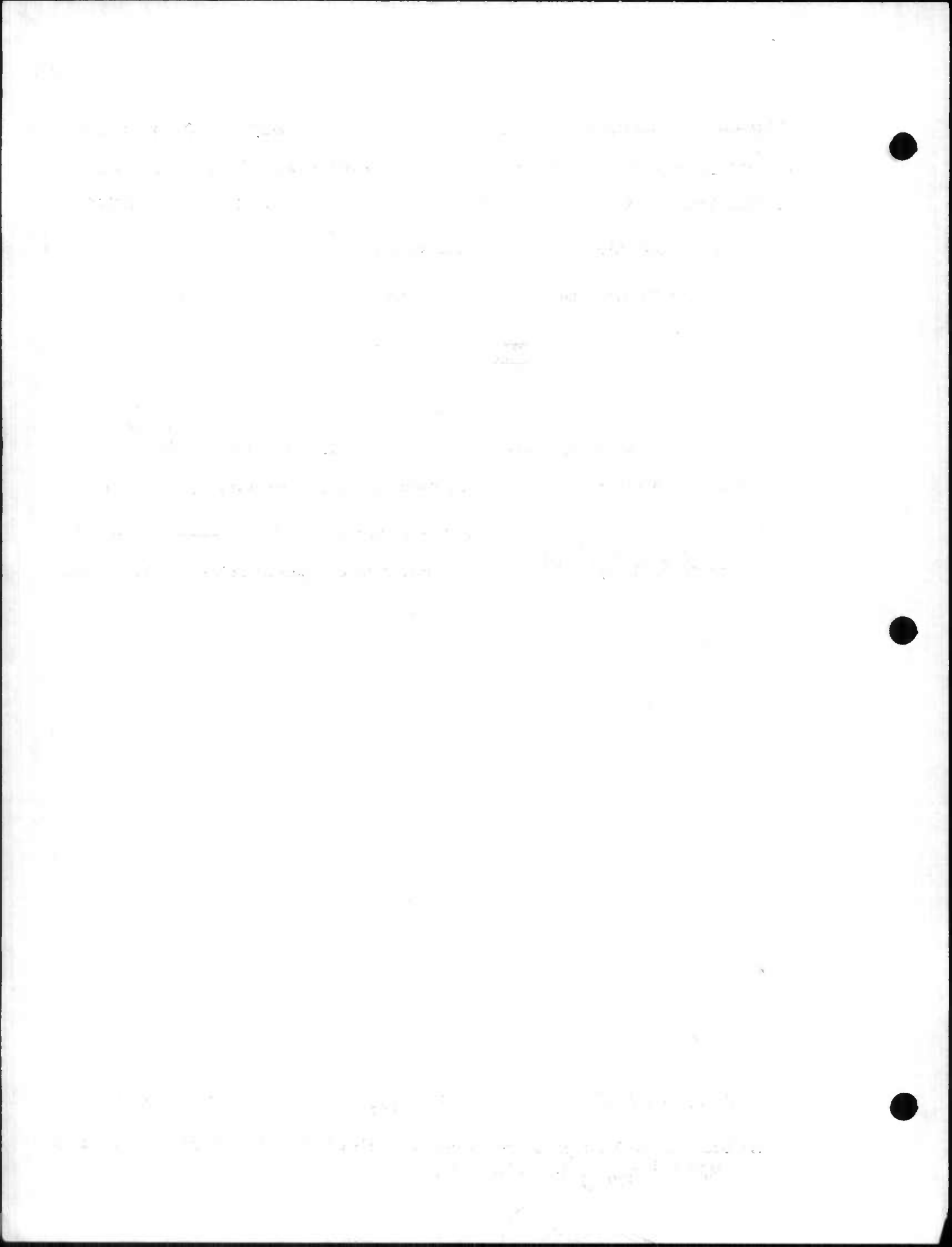
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Physician  
/Medical  
Examiner

**Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician  
/Medical  
Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Anna Katherina Feikert Clifford		May 5, 1996		5:30 AM	
4a. Facility Name (If not Institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Sunrise of Towson -Assisted Living		Towson		Baltimore County	
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 73	
523-26-9699					
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
		Sept 7, 1922		Kansas	
10a. State		10b. County		10c. City, Town or Location	
Maryland		N/A		Baltimore City	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
5705 Roland Avenue		21210		USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
8 yrs		Homemaker		Own Residence	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Sumama)			
Jacob Feikert		Katherina Rath			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Brett D. Clifford (Son)		909 Rolandvue Avenue, Towson, MD 21204			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
		Green Mount Crematory		5/7/96 Baltimore, Maryland	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
Martin D. Lawson (M00358)		Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		2 years			
a. Metastatic Breast Cancer		Due to (or as a consequence of):			
b.		Due to (or as a consequence of):			
c.		Due to (or as a consequence of):			
d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William D. McConnell M.D.		29c. License number MD 42129	
				29d. Date signed (Month, Day, Year) 5-6-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. McConnell, M.D., 500 W. University Parkway, Baltimore, Maryland 21210					
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature [Signature]			





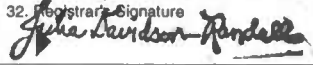
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State of Maryland / Department of Health and Mental Hygiene

96 13356

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Frederick Cogswell</b>					2. Date of Death Month Day Year <b>May 2 1996</b>		3. Time of Death <b>7:30 P.M.</b>					
	4a. Facility Name (If not institution, give street and number) <b>201 Sycamore Road</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Anne Arundel</b>					
Funeral Director	5. Social Security Number <b>219 12 3371</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 10, 1924</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>			
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					10e. Street and Number <b>201 Sycamore Road</b>		10f. Zip Code <b>21226</b>		10g. Citizen of What Country? <b>U.S.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W. II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teletype Serviceman</b>		
	16b. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>Frederick Cogswell</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Medinger</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Marie C. Smith</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31 Robin Lane Williamsburg, Pennsylvania 16693</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>						
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>1 year</b>												
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier 					29c. License number <b>D39505</b>		29d. Date signed (Month, Day, Year) <b>May 3, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>YUDHISHTRA MARKAN 1406-B CRAIN HWY #202 GLEN BURNIE MD. 21061</b>													
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>					32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or immediate or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

ZZ + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13357

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAURICE COATES</b>				2. Date of Death Month <b>May</b> Day <b>01</b> Year <b>1996</b>		3. Time of Death <b>4:30 PM.</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHOCK TRAUMA</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>217-04-2384</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>28</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 14 1967</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>2330 W. FAYETTE STREET</b>			10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>CUSTODIAN</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>JOHNSON CONTROL WORLD</b>		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>JOHN COATES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALICE CRAYTON</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Alice Coates/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2330 W. Fayette Street, Baltimore Maryland 21223</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		Date <b>5-6-96</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>12 WILLIAM C. BROWN COMMUNITY F/H 06 W. North Avenue</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE GUNSHOT WOUNDS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>4/30/96</b>		28b. Time of injury <b>1320 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT SHOT</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 02, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. GOLLE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 13358

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Dorothy Cook</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 29, 1996</b>		3. TIME OF DEATH <b>1:00p M</b>	
4. SOCIAL SECURITY NUMBER <b>230-22-8067</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 22, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>5305 Chrysler Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5305 Chrysler Avebnue</b>			
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>N/A</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Pryor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Albert Cook</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5305 Chrysler Avenue Balt. Md. 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery 5/1/96 Baltimore, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay L. Koller</i>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Home Inc. 2501 Gwynns Falls Pky Balt. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarct</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Arteriosclerotic Cardiovascu- lar Disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid Arthritis COPD</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Enrique</i>				29c. LICENSE NUMBER <b>D14829</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/1/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALEJANDRO C. ENRIQUE, 2435 W Belvedere</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <i>Gina Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13359

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rosaria Cirone</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>12:25pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Crofton Convalescent Center</b>				4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>323-16-0978</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Dec. 1, 1908</b>	9. Birthplace (State or Foreign Country) <b>Illionis</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Crofton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2131 Davidsonville Road</b>			10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John Baptista Oliveri</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Antonia Bucaro</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Salvatore Cirone</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>251 Linden Hall Court, Riva, MD 21140</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph Cemetery</b>		Date <b>5/4/96</b>		20c. Location - City or Town, State <b>River Grove, IL</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Alzheimer's Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>2 months</b> <b>10 yrs.</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Manic Depressive Illness.</b> <b>Atherosclerotic Cardiovascular Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number <b>014753</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>86201.1. Betty Alice Hall, Randallstown, Maryland 21133</b>							
	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 					



DEATH VERIFICATION ON-LINE

BATCH NUM:                      CERTIFICATE NUM: 13360      DATE OF DEATH: 05/05/1996  
FIRST NAME: LUCIA MARIA                      SEX: 2      AGE: 0      61      M STATUS: 2  
                    LAST: CAPELLA                      PLACE OF DEATH: 5                      DISPOSITION: 1  
SS NUM: 215-30-2824                      IMMED CAUSE: 0000                      AUTOPSY: 9

DATE FILED: 05/07/1996                      FINDINGS: 9                      CERTIFIER: 1  
DATE OF BIRTH: 08/09/1934                      MANNER OF DEATH: 1                      AT WORK:  
ADDRESS: 3507 NORTHWAY DR                      ZIP CODE: 21234                      CENSUS: 270501  
FATHERS NAME: BONACOSIA                      FUNERAL HOME: RUCK FH

HISPANIC: 0                      RACE: 1                      RESIDENCE STATE: 35  
BIRTH PLACE: 35                      COUNTY: 300  
COUNTY OF DEATH: 30                      ALLOCATION: 1  
PLACE OF INJURY:                      MAIDEN NAME: CORTILLO  
LOCATION:                      EDUCATION:                      12  
                    FACILITY : 00

MATCHED :

PF4: NEXT REC      ENTER: PROCESS      CLEAR: MENU

MESSAGE:

3/26/2008  
Original Death Cert.  
Missing.

\*Will Microfilm if found.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13361

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JUNIOR CHAVIS</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>11:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Church Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>246-24-6966</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04/13/1923</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>129 N. Ellwood Ave.</b>		10f. Zip Code <b>21224</b>		
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>American Indian</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steelworker</b>		16b. Kind of Business/Industry <b>Steel</b>		
17. Father's Name (First, Middle, Last) <b>Preston Chavis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Learann Gibbs</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Evelean Chavis Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>129 N. Ellwood Ave. Baltimore, Md 21224</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>		20d. Date <b>5/6/96</b>		
21. Signature of Funeral Service Licensee <b>Kathleen Weber CFSP</b>				22. Name and Address of Facility <b>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic prostate carcinoma</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>Dr. Chavis</b>				29c. License number <b>D-4054</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR CHAVIS 100 NORTH BROADWAY BALTIMORE, MD 21231</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

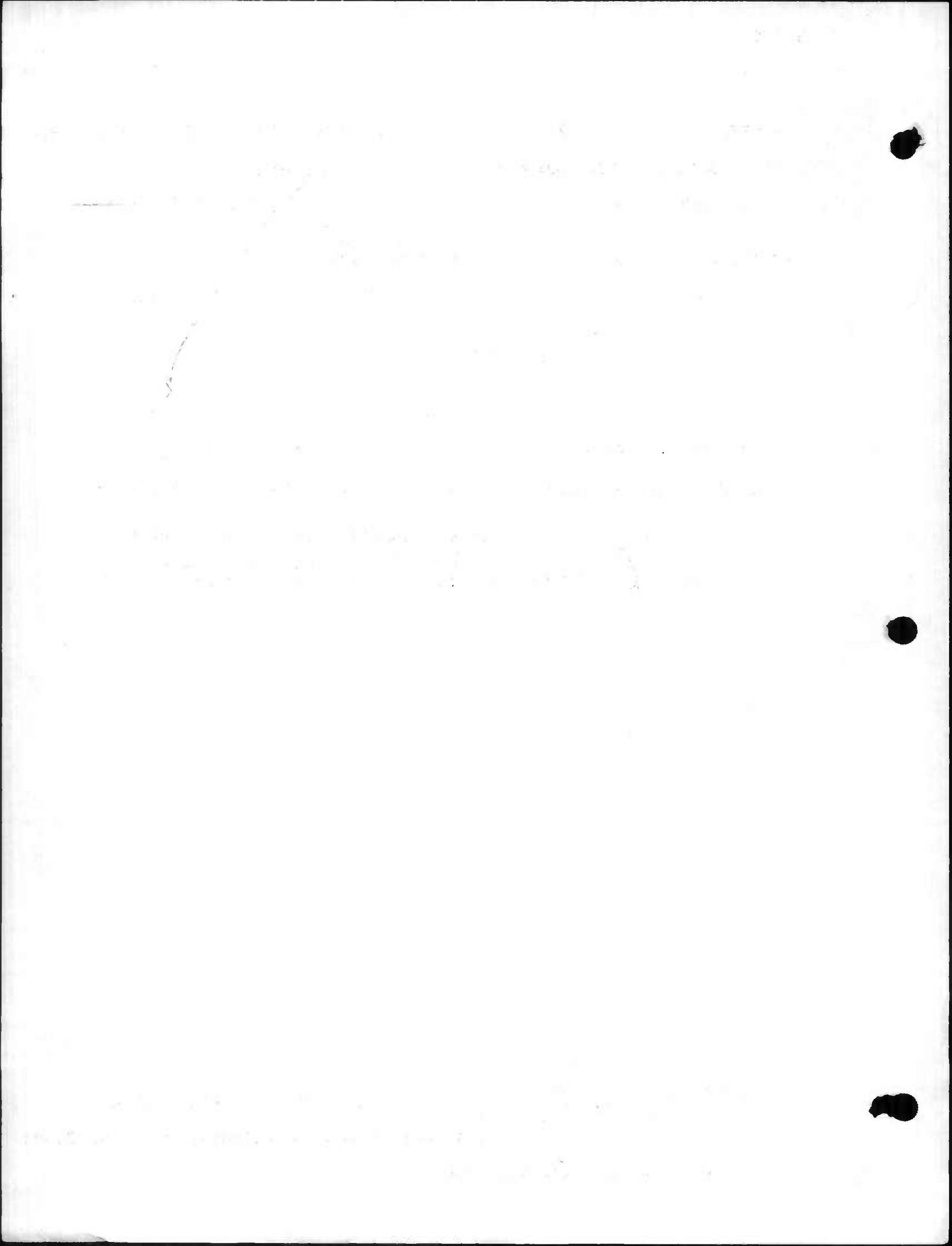
1. Decedent's Name (First, Middle, Last) <b>HULBERT J. CLARKE</b>			2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1996</b>			3. Time of Death <b>6:35 P.M.</b>		
4a. Facility Name (If not institution, give street and number) <b>4000 BLK. CHESTERFIELD AVE</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>		
5. Social Security Number <b>110-62-2656</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>X</b>	7. Age (In yrs. last birthday) <b>18</b> Yrs.		If Under 1 Year Month <b>5</b> Day <b>13</b>	If Under 24 Hrs. Hours <b>18</b> Min. <b>35</b>	8. Date of Birth (Month, Day, Year) <b>MAY 21, 1977</b>	
9. Birthplace (State or Foreign Country) <b>GUAYANA</b>								
10a. State <b>MARYLAND</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>BALTIMORE CITY</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>3829 BONVIEW</b>			10f. Zip Code <b>21213</b>		
10g. Citizen of What Country? <b>U.S.A.</b>			11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>3/13/96</b>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>N/A</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>			16b. Kind of Business/Industry <b>N/A</b>			17. Father's Name (First, Middle, Last) <b>HULBERT W. CLARKE</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>INGRID A. STANTON</b>			19a. Informant's Name/Relationship (Type, Print) <b>INGRID STANTON-MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3829 BONVIEW BALTO, MD. 21213</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY MAY 8, 1996 BALTO, MD.</b>			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i>			22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD, 21213</b>					

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple gunshot wounds</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>STREET</b>		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>5/13/96</b>		
28b. Time of Injury <b>1830 M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Subject shot</b>			28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>4000 block Chesterfield Avenue Baltimore Maryland</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Theodore M. King</i>		
29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>MAY 4, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature <i>John D. ...</i>		

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13363

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARLAR CURBEAN				2. Date of Death Month Day Year MAY 2 1996		3. Time of Death 2:53 pm		
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE at MERCY				4b. City, Town, or Location of Death baltimore		4c. County of Death n/a		
Funeral Director	5. Social Security Number 216-10-0479		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year MAR 3, 1910	9. Birthplace (State or Foreign) S. CAROLINA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1118 E. 20 th STREET				10f. Zip Code 21218		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CORK OVEN		16b. Kind of Business/Industry BETHLEHEM STEEL				
	17. Father's Name (First, Middle, Last) JOSEPH CURBEAN				18. Mother's Name (First, Middle, Maiden Surname) ESTHER BROWN				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MARTHA JACKSON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 E. 20 th STREET, BALTIMORE, MD 21218				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK		Data 5-7		20c. Location - City or Town, State ARBUTUS, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WM. C. MARCH FH. 01101 E. NORTH AVENUE				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic rectal cancer</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) stella maris at mercy Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D740480		29d. Date signed (Month, Day, Year) MAY 4, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO V. FERRERO, MD 5810 ISLAKR RD BETHESDA, MD 21206									
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13364

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JUANITA B. DWORKOWSKI.</u>				2. Date of Death Month <u>MAY</u> Day <u>4</u> Year <u>1996</u>		3. Time of Death <u>7:15AM</u>	
	4e. Facility Name (If not institution, give street and number) <u>EXTENDED CARE FACILITY, HARBOR HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>BALTIMORE City</u>	
Funeral Director	5. Social Security Number <u>186 16 5787</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>75</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>July 21, 1920</u>	9. Birthplace (State or Foreign Country) <u>New York</u>
	Usual Residence of Decedent							
10e. State <u>Maryland</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Linthicum</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>714 E. Maple Road</u>				10f. Zip Code <u>21090</u>		10g. Citizen of What Country? <u>U.S.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2 years</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Tester</u>			16b. Kind of Business/Industry <u>Western Electric</u>	
17. Father's Name (First, Middle, Last) <u>Patrick Bowers</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Anna VanHorn</u>				
19e. Informant's Name/Relationship (Type, Print) <u>Milton Dworkowski</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>714 E. Maple Road Linthicum, Maryland 21090</u>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Md. State Veteran Cem.</u>		Date <u>5/7/96</u>		20c. Location - City or Town, State <u>Crownsville, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Jeane Mamiciowski</u>				22. Name and Address of Facility <u>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
e. <u>ACUTE RENAL FAILURE.</u>								<u>4 days approx.</u>
Due to (or as a consequence of):								
b. <u>SEPSIS.</u>								<u>20 days.</u>
Due to (or as a consequence of):								
c. <u>LEG ULCER</u>								<u>30 days.</u>
Due to (or as a consequence of):								
d. <u>DIABETES MELLITUS.</u>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
<u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>								
<u>HYPOTHYROIDISM.</u>								
<u>CONGESTIVE HEART FAILURE.</u>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitals: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <u>Resident. Internal Medicine</u>				29c. License number <u>AS 244161437.</u>		29d. Date signed (Month, Day, Year) <u>MAY 4, 1996</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>MUHAMMAD N. FIRDZ. HARBOR HOSPITAL CENTER 3001 S. HANOVER ST. BALTIMORE MD 21225</u>								
31. Date filed (Month, Day, Year) <u>MAY 07 1996</u>				32. Registrar's Signature <u>Julia Davidson-Randall</u>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13365

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Benson Eichler</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>9:20 am</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216-24-5354</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 14, 1928</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TIMONIUM</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3 Harding St.</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Newspaper Carrier</b>			16b. Kind of Business/Industry <b>Balto. Sun</b>		
	17. Father's Name (First, Middle, Last) <b>John Christopher Eichler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Marian Brown</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elaine P. Eichler</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Harding St., Timonium, MD 21093</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens</b>		Date <b>MAY 6</b>		20c. Location - City or Town, State <b>Timonium, MD</b>	
	21. Signature of Funeral Service Licensed <b>Bryan W. Clary</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarct</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis, Status post total knee replacement</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Steven H. Pearlman</b>				29c. License number <b>D30206</b>		29d. Date signed (Month, Day, Year) <b>5/3/1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven H. Pearlman, M.D. - GBMC 6701 N Charles St Baltimore MD 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>J. Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13366

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HANNAH EVANS</b>				2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>2:35AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>249-09-3025</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUN. 23, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>S. CAROLINA</b>		10a. State <b>MD</b>		10b. County <b>na/</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1054 LUZERNE AVENUE</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2nd</b> College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE'S AIDE</b>		16b. Kind of Business/Industry <b>CITY HOSPITAL</b>			
	17. Father's Name (First, Middle, Last) <b>BEN PIERCE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BELL JAMES</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>JOSEPHINE SETTLERS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>816 N. BELNORD AVENUE, BALTIMORE, MD 21205</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD. NATIONAL CEMETERY 5-8</b>		Date <b>LAUREL, MD</b>		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>UROSEPSIS</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>2 Days.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 		29c. License number <b>AS 2402321-AB-9911</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SINAI HOSPITAL 2401 BELVEDERE AVE.</b>							
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To be Completed by Physician/Medical Examiner: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13367

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OMA RUTH FOSTER				2. Date of Death Month Day Year May 3, 1996		3. Time of Death 12:30pm	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220 24 9747A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 21, 1929	
	9. Birthplace (State or Foreign Country) Pennsylvania							
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2300 Dulaney Valley Road				10f. Zip Code 21204		10g. Citizen of What Country? U.S.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 5 +				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Science	
17. Father's Name (First, Middle, Last) Raymond Foster				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Coleman				
19a. Informant's Name/Relationship (Type, Print) Evelyn Elson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Vally Road Pasadena, Maryland 21122				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Data 5/8/96		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Jerome Z...</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. OVARIAN CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 7 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Kendall R Faulkner</i>				29c. License number D25643		29d. Date signed (Month, Day, Year) 5/3/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204								
31. Date filed (Month, Day, Year) MAY 07 1996				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

4

State  
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the challenges associated with maintaining accurate records. It identifies common sources of error and provides guidance on how to minimize these errors through careful attention to detail and the use of appropriate controls.

4. The fourth part of the document discusses the role of technology in improving record-keeping. It highlights the benefits of using automated systems to process transactions and generate reports, while also noting the importance of ensuring that these systems are secure and reliable.

5. The fifth part of the document provides a summary of the key points discussed in the previous sections. It reiterates the importance of accurate record-keeping and the need for ongoing monitoring and improvement of the record-keeping process.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13368

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mark R. Flora

2. Date of Death

05 01 Day 1996 Year

3. Time of Death

9:00pm

4a. Facility Name (If not institution, give street and number)

1400 West 37th Street

4b. City, Town, or Location of Death

Balto

4c. County of Death

City

Funeral  
Director

5. Social Security Number

820-03-5521

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3/25/1904

9. Birthplace (State or Foreign Country)

Balto

Usual Residence of Decedent

10a. State

MD

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XXX Yes 2 ☐ No

10e. Street and Number

1400 West 37th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PAPER HANGER

16b. Kind of Business/Industry

Residential

17. Father's Name (First, Middle, Last)

Will FLORA

18. Mother's Name (First, Middle, Maiden Surname)

MARY FLORA

19a. Informant's Name/Relationship (Type, Print)

Sadie Flora

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1400 West 37th Street Baltimore, MD 22211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Data

5/6/96

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home  
3631 Falls Rd Balto, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary tract infection

Debilitation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

041614

29d. Date signed (Month, Day, Year)

May 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alan Hille, 711 West 40th St Ste. 400 Balto, MD 21211

31. Date filed (Month, Day, Year)

MAY 07 1996

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13369

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WADE RECARDO GASQUE</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>8:25 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice Mercy</b>				4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-56-2954</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 23, 1950</b>	9. Birthplace (State or Foreign Country) <b>md</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>		10b. County <b>N/A</b>		10c. City, Town, or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>218 mt. Holly st.</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>4 yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>License Practical Nurse</b>		16b. Kind of Business/Industry <b>Rosewood state Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Wade Gasque</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Queen Evans</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Antonio Gasque - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9115 Groffsmill Dr. Owings Mills, md 21117</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Date <b>5/7/96</b>		20d. Location - City or Town, State <b>Woodlawn, md</b>	
	21. Signature of Funeral Service Licensee <b>Stella March</b>				22. Name and Address of Facility <b>March F.H. - West 4300 Wabash Ave</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Approximate Interval Between Onset and Death <b>7 yrs.</b>							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Kendall R Faulkner</b>				29c. License number <b>025643</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>							
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>				32. Registrar's Signature <b>Kendall R Faulkner</b>				





96 13370

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>George W. Hoffman</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>06</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>12:45 p.m.</u>	
4. SOCIAL SECURITY NUMBER <u>217 18 7062</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>83</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 21, 1912</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Fallston General Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Fallston</u>		9c. COUNTY OF DEATH <u>Harford</u>	
10a. STATE <u>Pennsylvania</u>				10b. COUNTY <u>York</u>		10c. CITY, TOWN OR LOCATION <u>Delta</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <u>808 Main St.</u>				10f. ZIP CODE <u>17314</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Self employed / owner</u>		16b. KIND OF BUSINESS/INDUSTRY <u>General Store / retail</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Samuel W. Hoffman</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Jessie M. Snyder</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Jeanette Hoffman</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>808 Main St., Delta, PA 17314</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Mount Crematory 5/7/96</u>		20c. LOCATION — City or Town, State <u>Baltimore, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Stephen D. Lohrmann</u>				22. NAME AND ADDRESS OF FACILITY <u>CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Progressive Chronic Obstructive Pulmonary Disease</u> <u>2 yrs</u>					
		b. <u>with Sarcoidosis</u>					
		c. <u>Pulmonary Hypertension</u> <u>2 months</u>					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Malnutrition</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William P. Amos</u>				29c. LICENSE NUMBER <u>004354</u>		29d. DATE SIGNED (Month, Day, Year) <u>May 6, 1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>William P. Amos, 2303 Beland Rd, Fallston, md 21047</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 07 1996</u>		32. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96-2359-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 23 PART I, 27, PER MEO

State of Maryland / Department of Health and Mental Hygiene

96 13371

FILM G-735 5/7/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARLTON E.				2. Date of Death Month Day Year APRIL 30 1996				3. Time of Death 9:03A.M.	
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-50-9122		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 56		8. Date of Birth (Month, Day, Year) 2/29/40		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Pr. George		10c. City, Town or Location Ft. Washington				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 8101 Allentown Rd.				10f. Zip Code 20744		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry None		
	17. Father's Name (First, Middle, Last) Fielder D. Hays					18. Mother's Name (First, Middle, Maiden Surname) Virginia G. Davis				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Paul G. Hause				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Fenwood Ave. Oxon Hill, Md. 20745					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 5/4/96		20c. Location - City or Town, State Suitland, Md.			
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <i>error</i> <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Dennis J. Chute MD</i>					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) MAY 2, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAY 07 1996										
32. Registrar's Signature <i>John Davidson Randall</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13372

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD FRANKLIN HORNEY, SR.				2. Date of Death Month Day Year May 1, 1996		3. Time of Death 1:00 PM	
	4e. Facility Name (If not institution, give street and number) 1621 Tieman Drive, 21061				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 214-03-5446		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Dec 28, 1916	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1621 Tieman Drive		10f. Zip Code 21061		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Pump Mechanic		16b. Kind of Business/Industry Conoco Oil Co.			
	17. Father's Name (First, Middle, Last) Aaron R. Horney				18. Mother's Name (First, Middle, Maiden Surname) Edna Nina (unknown)			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Kimberly Lansaw-Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1091 Holmespun Drive, Pasadena, Md. 21122			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Pk.		20c. Date 5/4/96		20d. Location - City or Town, State Glen Burnie, Maryland	
	21. Signature of Funeral Service Licensee Kevin E. Ecker				22. Name and Address of Facility McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225-1856			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrest</u> Due to (or as a consequence of): b. <u>Myocardial Infarction</u> Due to (or as a consequence of): c. <u>Arteriosclerotic Disease</u> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5/1/96		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D18612		29d. Date signed (Month, Day, Year) May 2, 1996		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dr. Gelsimo A. Cruz, M.D. 300 Hospital Drive, Suite 230, Glen Burnie, Md. 21061								
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13373

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Norma Trout Haire</u> NORMA T. HAIRE				2. Date of Death Month <u>May</u> Day <u>4</u> Year <u>1996</u>		3. Time of Death <u>1915</u> PM										
	4a. Facility Name (If not institution, give street and number) <u>Franklin Square</u>				4b. City, Town, or Location of Death <u>Rossville</u>		4c. County of Death <u>Baltimore</u>										
Funeral Director	5. Social Security Number <u>220-40-8544</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>53</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>March 9, 1943</u>										
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Dundalk</u>										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>7922 N. Boundary Road</u>		10f. Zip Code <u>21222</u>		10g. Citizen of What Country? <u>United States</u>										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>3 years</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Data Analyst</u>		16b. Kind of Business/Industry <u>Aero Space</u>												
	17. Father's Name (First, Middle, Last) <u>George F. Trautman</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Theresa M. Gaster</u>												
	19a. Informant's Name/Relationship (Type, Print) <u>Gail L. Haire (Daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8050 Del Haven Road Dundalk, Maryland 21222</u>												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		20c. Date <u>5/8/96</u>		20d. Location - City or Town, State <u>Baltimore, Md. 21225</u>										
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</u>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <u>Respiratory Failure</u> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <u>48 Hours</u></td> </tr> <tr> <td>b. <u>Small Cell Lung Cancer</u> Due to (or as a consequence of):</td> <td><u>3 Months</u></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Respiratory Failure</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>48 Hours</u>	b. <u>Small Cell Lung Cancer</u> Due to (or as a consequence of):	<u>3 Months</u>	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Respiratory Failure</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>48 Hours</u>														
b. <u>Small Cell Lung Cancer</u> Due to (or as a consequence of):		<u>3 Months</u>															
c. _____ Due to (or as a consequence of):																	
d. _____ Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <u>H. Babali, MD</u>				29c. License number <u>D46179</u>		29d. Date signed (Month, Day, Year) <u>May 4th, 1996</u>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>HOSSEIN BABALI, MD 6201 Loch Raven BLVD, APT 610, BALTIMORE, MD 21239</u>																	
31. Date filed (Month, Day, Year) <u>MAY 07 1996</u>		32. Registrar's Signature <u>[Signature]</u>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 13374

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JUDITH P. HARRISON</b>				2. DATE OF DEATH MONTH <b>MAY</b> - DAY <b>3</b> - YEAR <b>1996</b>		3. TIME OF DEATH <b>10:55 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-2596</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 21, 1906</b>	
8. FACILITY NAME (If not institution, give street and number) <b>LORIEN NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>COLUMBIA</b>		9c. COUNTY OF DEATH <b>HOWARD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1338 POPLAR AVENUE</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12TH GRADE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOMEMAKING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN W. HOLLINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BEULAH WARD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>P. ELAINE HARRISON (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1338 POPLAR AVENUE - BALTIMORE, MD 21227</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>5/6</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Devoe L. Klug</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Dysrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death <b>immediate</b> <b>2 months</b> <b>1 month</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mult. CVA's, HTN, decubitus ulcers</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Day, Jr.</i>				29c. LICENSE NUMBER <b>JD 42187</b>		29d. DATE SIGNED (Month, Day, Year) <b>23 May 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES A. DAY, JR 11055 Little Patuxent Parkway Columbia MD 20866</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10



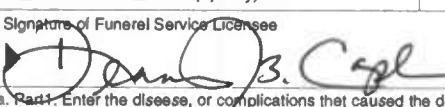
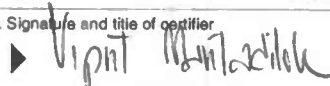
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13375

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leola W Jackson</b>				2. Date of Death Month <b>May</b> Day <b>02</b> Year <b>96</b>		3. Time of Death <b>1355</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-22-3085</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT 28, 1917</b>	9. Birthplace (State or Foreign Country) <b>NC.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>412 NORTH ATHOL STREET APT D</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		16b. Kind of Business/Industry <b>BOX FACTORY</b>			
	17. Father's Name (First, Middle, Last) <b>LEX WHITE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GEORGIA CROWDER</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>HARRY JACKSON (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>412 N. ATHOL ST. APT D BALTO, MD. 21229</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEM PK</b>		Date <b>5/07/96</b>		20c. Location - City or Town, State <b>ARBUTUS, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAPLE FUNERAL SERVICE</b> <b>5502 WINNER AVENUE BALTIMORE, MD 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>2 DAYS</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>P 08217</b>		29d. Date signed (Month, Day, Year) <b>May 2nd, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VIPUT MANTAOILICH SAINT AGNES HOSPITAL BALTIMORE, MARYLAND.</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13376

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH IRENE JONES</b>				2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>11:40 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>430-05-0419</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 27, 1912</b>	9. Birthplace (State or Foreign Country) <b>Arkansas</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>633 Anneslie Road</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>12 years</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Wade Everett Balentine</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah P. Davenport</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Fred J.B. Jones Sr. husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>633 Anneslie Road, Baltimore, MD 21212</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Date <b>May 7</b>		20c. Location - City or Town, State <b>Timonium, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>INTRACEREBRAL HEMORRHAGE</b>								
	23b. Approximate Interval Between Onset and Death <b>10 HOURS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D 30263</b>		29d. Date signed (Month, Day, Year) <b>05-04-96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHOO, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

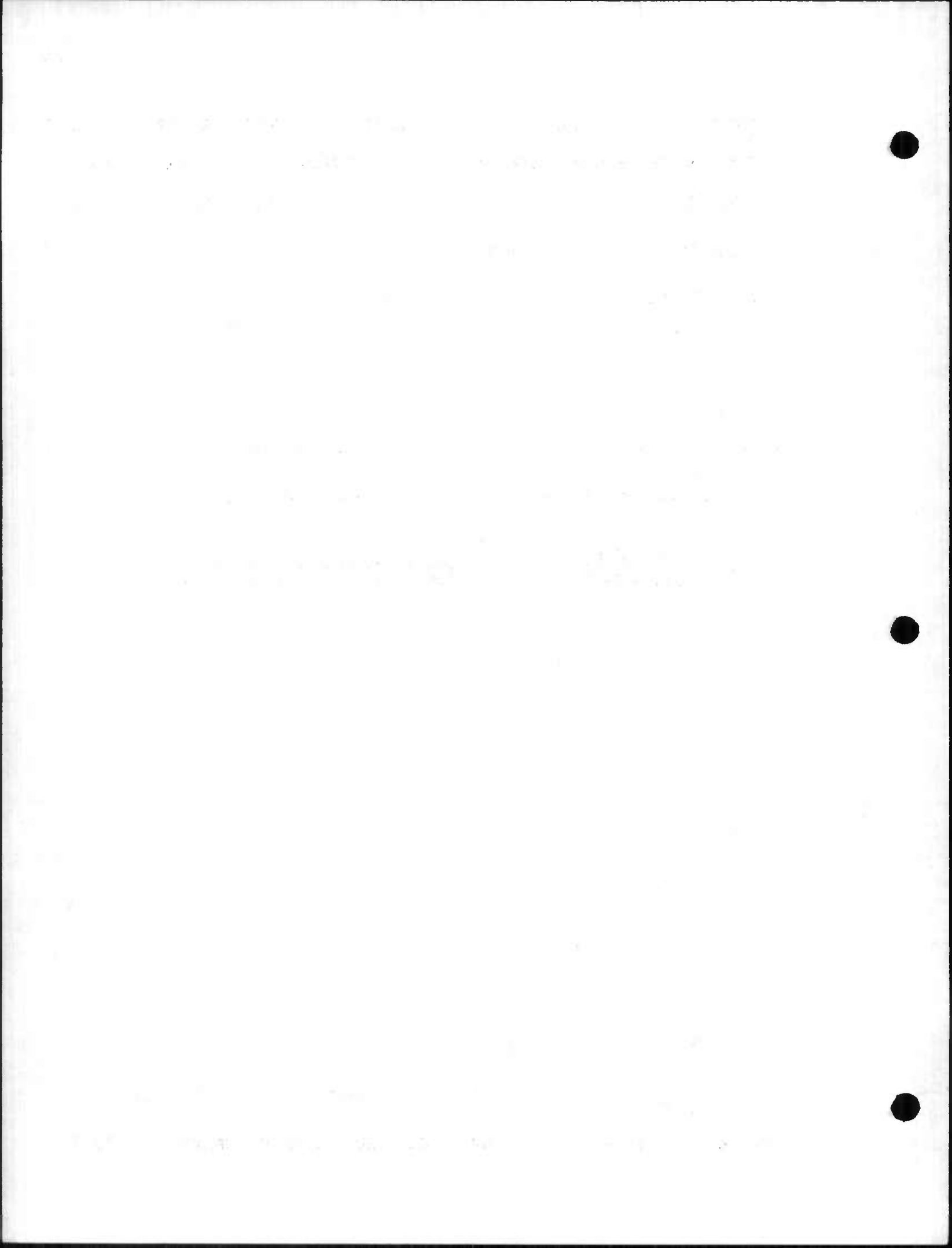
Immediate Cause (Final disease or condition resulting in death)

INTRACEREBRAL HEMORRHAGE

10 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):



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State of Maryland / Department of Health and Mental Hygiene

96 13377

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS E. JOHNSON</b>				2. Date of Death Month <b>MAY</b> Day <b>05</b> Year <b>96</b>		3. Time of Death <b>12:01P</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-01-6218</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 16, 1918 Maryland</b>	
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Arbutus</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1275 Brewster Street</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-12</b> College (1-4 or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>home maker</b>		16b. Kind of Business/Industry <b>own home</b>	
	17. Father's Name (First, Middle, Last) <b>Joseph F. Rottman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian M. Mansdorfer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Elmer L. Johnson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1275 Brewster Street Baltimore, Maryland 21227</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery</b>		20c. Location - City or Town, State <b>5/8/96 Dorsey, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ambrose Funeral Home, inc. 1328 Sulphur Spring Road 21227</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic lung cancer</b> Due to (or as a consequence of): <b>b. Coronary artery disease</b> Due to (or as a consequence of): <b>c. Diabetes mellitus</b> Due to (or as a consequence of): <b>d. Congestive heart failure</b>							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Andrzej J. Janicki M.D.</b>				29c. License number <b>D 47014</b>		29d. Date signed (Month, Day, Year) <b>MAY 05, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDRZEJ J. JANECKI M.D., JOHNS HOPKINS HOSPITAL, BALTO</b>							
	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Agnes Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Certificate of Death

Reg. No.

96 13378

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Phillip Kocher</b>				2. Date of Death Month <b>May</b> Day <b>03</b> Year <b>96</b>		3. Time of Death <b>5pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Ponder Drive</b>				4b. City, Town, or Location of Death <b>Edgewater</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>212-03-0634</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 12, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Edgewater</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>3840 Ponder drive</b>			10f. Zip Code <b>21037</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Buick Representative</b>		16b. Kind of Business/Industry <b>Automotive</b>			
	17. Father's Name (First, Middle, Last) <b>Phillip Kocker</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Basic</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Audrey Kocker</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3840 PONDER DR. EDGEWATER, MARYLAND 21037</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>5/8/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>HARDESTY FUNERAL HOME, P.A.</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>metastatic Carcinoma of the lung</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>3 yrs</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of Certifier 				29c. License number <b>D38563</b>		29d. Date signed (Month, Day, Year) <b>05/06/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne Bierbaum 134 Owensville Rd West River MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13379

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN Virginia KLINEDINST						2. Date of Death Month Day Year May 2, 1996		3. Time of Death 11:45 PM	
	4a. Facility Name (If not institution, give street and number) 3318 Washington Blvd.,						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-07-0286		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 3, 1918		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3315 Washington Blvd., Apt. D				10f. Zip Code 21223		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress				16b. Kind of Business/Industry Sewing Factory		
	17. Father's Name (First, Middle, Last) Raymond Ensey						18. Mother's Name (First, Middle, Maiden Surname) Annie Smith			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thomas H. Mertel - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 S. Stricker St., Balto., Md. 21223					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		Date 5/06/96		20c. Location - City or Town, State Elkridge, Md.			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. METASTATIC, PROGRESSIVE CERVICAL CANCER Due to (or as a consequence of): b. INTESTINAL OBSTRUCTION Due to (or as a consequence of): c. RENAL FAILURE Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Joseph Buscema, MD		29c. License number D25274		29d. Date signed (Month, Day, Year) MAY 3, 1996						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOSEPH BUSCEMA - 6569 N. CHARLES STREET - BALTIMORE, MD 21204										
State Registrar	31. Date filed (Month, Day, Year) MAY 07 1996				32. Registrar's Signature Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13380

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>CARRIE LOVETT</b>					2. Date of Death Month <b>5</b> Day <b>5</b> Year <b>96</b>		3. Time of Death <b>10:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>242-20-9855</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1911</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2012 Harlem Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>Furniture Store</b>			
17. Father's Name (First, Middle, Last) <b>William Garrell</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gail Cobb</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2012 Harlem Avenue, Baltimore, MD 21217</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>5/8</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>		
21. Signature of Funeral Service Licensee <i>LeRoy O. Dyett</i>					22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE, BALTO. 21207</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>Complete Heart Block</b></p> <p>Due to (or as a consequence of): <b>Asystole</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>EXTRAVENTRICULAR Conduction Repeat</b></p> <p><b>Cerebral Vascular Infarct</b></p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>8 days</b></p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Robert J. Williams MD</i>					29c. License number <b>D25055</b>		29d. Date signed (Month, Day, Year) <b>5/5/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROBERT J WILLIAMS 5602 BALLO NATIONAL PK 21228</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature <i>Davidson-Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-222-2222.

Physician  
/Medical  
Examiner

State  
Registrar



96 13381

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marvin Leach</i>				2. DATE OF DEATH MONTH DAY YEAR <i>May 5, 1996</i>		3. TIME OF DEATH <i>8:00 AM</i>	
4. SOCIAL SECURITY NUMBER <i>217-86-7191</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>34</i> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <i>February 22, 1962</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Baltimore</i>				9a. FACILITY NAME (If not institution, give street and number) <i>3102 Oakfield Avenue</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>MD</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>3102 Oakfield Avenue</i>	
10f. ZIP CODE <i>21216</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2 years</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Correctional Officer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Correction's</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Phillip Leach</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Laura M. Ricks</i>			
19a. INFORMANT'S NAME (Type, Print) <i>Shirley Leach Wife</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3102 Oakfield Avenue, Baltimore, Md. 21216</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cem. May 11, 1996</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carlton C. Douglas</i>				22. NAME AND ADDRESS OF FACILITY <i>Douglas Funeral Service, 1701 Maculloh St., Balto, Md. 21217</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Probable acute Myocardial Infarction</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerotic Heart Disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to IMMEDIATE cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes, Congestive Heart Failure, Coronary Artery Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rifat Aboussy MD</i>				29c. LICENSE NUMBER <i>D12729</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/6/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) <i>Rifat Aboussy MD 2800 Garrison Blvd 21216</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 07 1996</i>				32. REGISTRAR'S SIGNATURE <i>a. [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13382

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ray J. Lee</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>6:27 PM</b>																																															
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>																																															
Funeral Director	5. Social Security Number <b>250-54-3614</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 26, 1937</b>	9. Birthplace (State or Foreign Country) <b>S.C.</b>																																														
	Usual Residence of Decedent																																																					
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																														
	10e. Street and Number <b>3517 Gelston Drive</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A</b>																																															
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																																															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> College (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tanker man</b>		16b. Kind of Business/Industry <b>BG + E</b>																																															
	17. Father's Name (First, Middle, Last) <b>Josee Lee</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eliza Jane Mashack</b>																																																	
	19a. Informant's Name/Relationship (Type, Print) <b>Lillian Lee - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3517 Gelston Drive Baltimore, MD 21229</b>																																																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem Park</b>		Date <b>5/6/96</b>	20c. Location - City or Town, State <b>Arbutus, MD</b>																																																
	21. Signature of Funeral Service Licensee <b>Shannon Jones</b>				22. Name and Address of Facility <b>March F.H. West 4300 Wabash Ave Baltimore, MD 21215</b>																																																	
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">a. <b>Respiratory Arrest from Aspiration</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>30 minutes</b></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="7">b. <b>Metastatic Rectal Carcinoma</b></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. _____</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Respiratory Arrest from Aspiration</b>							Approximate Interval Between Onset and Death <b>30 minutes</b>	Due to (or as a consequence of):							Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Metastatic Rectal Carcinoma</b>							Due to (or as a consequence of):							c. _____							Due to (or as a consequence of):	d. _____						
Immediate Cause (Final disease or condition resulting in death)	a. <b>Respiratory Arrest from Aspiration</b>							Approximate Interval Between Onset and Death <b>30 minutes</b>																																														
	Due to (or as a consequence of):																																																					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Metastatic Rectal Carcinoma</b>																																																				
		Due to (or as a consequence of):																																																				
c. _____							Due to (or as a consequence of):																																															
d. _____																																																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																																						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown																																																						
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																																						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																														
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																																																
				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																																						
29b. Signature and title of certifier <b>George E. Wicks III M.D.</b>				29c. License number <b>D41365</b>		29d. Date signed (Month, Day, Year) <b>May 4, 1996</b>																																																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George E. Wicks III M.D. 2000 West Baltimore Street 21223</b>																																																						
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>				32. Registrar's Signature <b>Madison-Randall</b>																																																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13383

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Beverly S LLOYD

2. Date of Death

April 30 1996

3. Time of Death

600PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

216-28-9799

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/19/31

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

A Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1643 Colony Rd

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Aid

16b. Kind of Business/Industry

Bay Manor Nursing Home

17. Father's Name (First, Middle, Last)

Albert Bucy

16. Mother's Name (First, Middle, Maiden Summa)

Rawlings Kave

19a. Informant's Name/Relationship (Type, Print)

Eugene M. Lloyd

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1643 Colony Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery May 3, 1996

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home  
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

4 weeks

4 weeks

5 years

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28221

29d. Date signed (Month, Day, Year)

APRIL 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dan H. Schreyer, MD 301 Hospital Drive Glen Burnie Maryland 21061

31. Date filed (Month, Day, Year)

MAY 07 1996

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13384

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY LIBERATORE</b>					2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>96</b>			3. Time of Death <b>10:17 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>					4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>n/a</b>		
Funeral Director	5. Social Security Number <b>215-18-7611</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 31, 1922</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>430 S.Taylor Ave.</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>own home</b>				
	17. Father's Name (First, Middle, Last) <b>John Peters</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET Musselman</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>John Liberatore</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>430 S.Taylor Ave. Baltimore Md. 21221</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Baltimore MD.</b>				
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RIGHT SIDED HEART FAILURE</b> Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Dr. Andrew McWhorter MD</b>				29c. License number <b>AS240232</b>		29d. Date signed (Month, Day, Year) <b>1/5/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Andrew McWhorter 2401 West Belvedere Ave. Baltimore Md. 21215</b>											
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>											
32. Registrar's Signature <b>Anderson-Randall</b>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13385

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH B. MUNOZ</b>				2. Date of Death Month Day Year <b>MAY 02, 1996</b>		3. Time of Death <b>8:35 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>218-18-6354</b>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-05-1916</b>		
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>								
Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4100 NORTH CHARLES STREET</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 YEARS</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES REPRESENTATIVE</b>			16b. Kind of Business/Industry <b>ADVERTISING</b>		
17. Father's Name (First, Middle, Last) <b>WILLIAM ALFRED NAIRN' BOWLAND</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH RISK WILEY</b>					
19a. Informant's Name/Relationship (Type, Print) <b>NAIRN' B. GILLET (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5046 BARRINGTON CIRCLE, SARASOTA, FL., 34234</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY</b>		Date <b>5-7-96</b>		20c. Location - City or Town, State <b>BALTO., MD., 21202</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LUNG CANCER, SMALL-CELL</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 mos.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

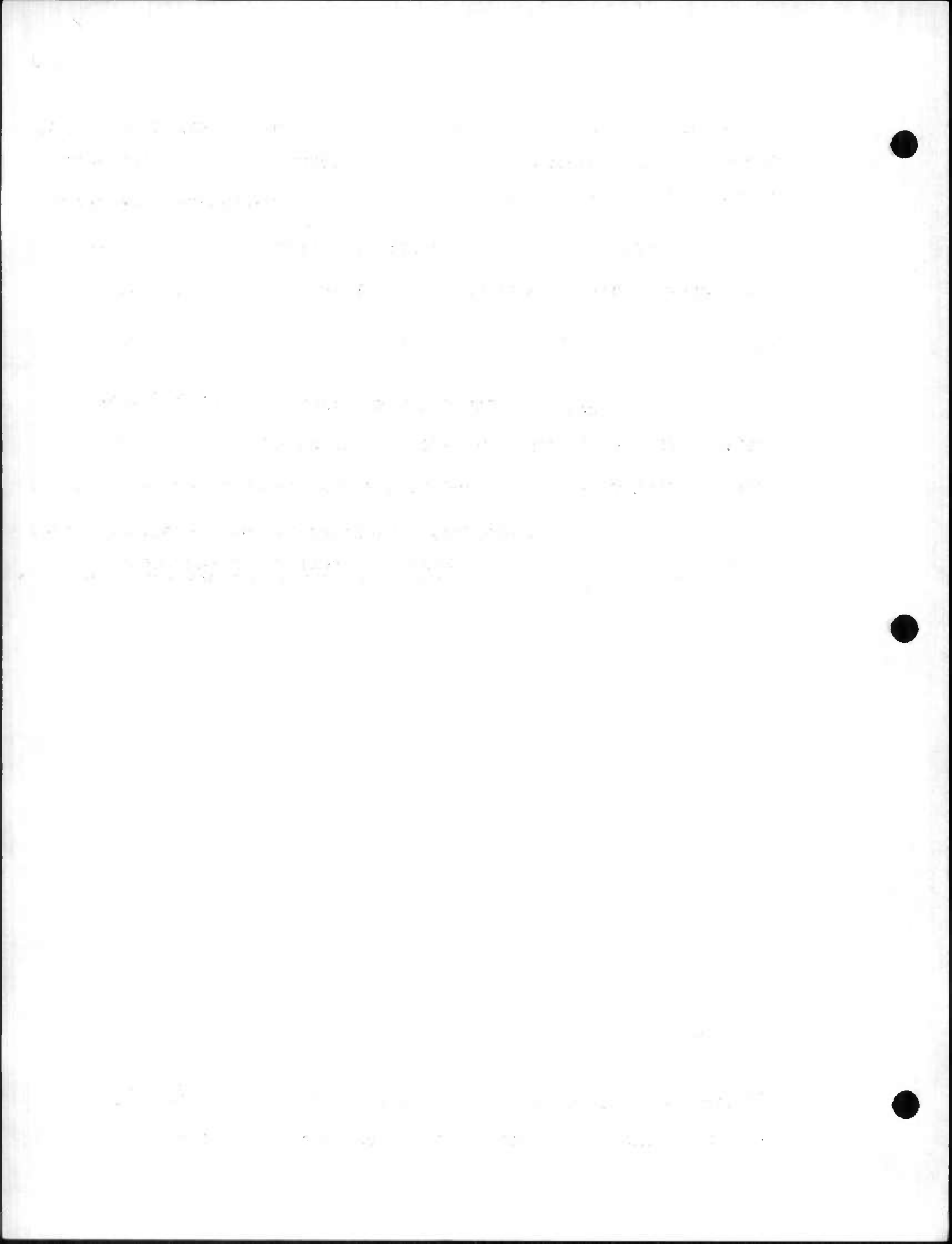
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

110

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13386

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles D. McNelly</b>						2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>8:50pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Long Green Nursing Center</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-10-0659</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 22, 1919</b>		9. Birthplace (State or Foreign Country) <b>Balto, MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>City</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b>		
10e. Street and Number <b>4317 Newport Avenue</b>				10f. Zip Code <b>21211</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>XX</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>				16b. Kind of Business/Industry <b>BGE</b>		
17. Father's Name (First, Middle, Last) <b>Frank D. Mc Nelly</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Bartell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Vernon McNelly</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4315 Newport Avenue Balto, MD 21211</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Crematory</b>			20c. Location - City or Town, State <b>5/6 Towson, MD</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Burgee-Henss Funeral Home 3637 Falls Rd. Balto, MD 21211</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <i>Malnutrition and dehydration</i> Due to (or as a consequence of):</p> <p>b. <i>Carcinoma of the lung</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> </div>										Approximate Interval Between Onset and Death <b>2 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>COPD, CAD</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D 28987</b>			29d. Date signed (Month, Day, Year) <b>5-6-96</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTIMORE MD 21239</b>										
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature <i>[Signature]</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NINA NEWTON McDONNELL</b>				2. Date of Death Month <b>5</b> Day <b>4</b> Year <b>96</b>		3. Time of Death <b>3:40</b>		
	4e. Facility Name (if not institution, give street and number) <b>Meridian Multi Med</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>233-03-9658</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>88</b> <del>89</del> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 18, 1907</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1607 Charlotte Avenue</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laboratory Technician</b>		16b. Kind of Business/Industry <b>Manufacturing</b>				
	17. Father's Name (First, Middle, Last) <b>Isaac Newton Marshall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Knight</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Jane Walzog (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>201 Brightdale Road Timonium, Maryland 21093</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>5/7/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CARDIO-RESPIRATORY ARREST</b> 12 Hours Due to (or as a consequence of):  b. <b>CONGESTIVE HEART FAILURE</b> 2 DAYS Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>CEREBROVASCULAR INSUFFICIENCY</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Howard B. Chen, M.D.</b>							
29c. License number <b>221680</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6717 Park Heights Avenue Baltimore 21215</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>Jalil Shadman-Randall</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13388

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Philip Leonard Moxey</b>						2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>08:00</b>	
4a. Facility Name (If not institution, give street and number) <b>8154 Gray Haven Road</b>						4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>215-12-9365</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 8, 1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8154 Gray Haven Road</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>		16b. Kind of Business/Industry <b>Food Industry</b>			
17. Father's Name (First, Middle, Last) <b>Jacob Moxey</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Era</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gloria K. Moxey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8154 Gray Haven Road Dundalk, MD 21222</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>5/7/96</b>		20c. Location - City or Town, State <b>Rossville, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hypoxia</b> Due to (or as a consequence of): <b>Emphysema</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b>								Approximate interval Between Onset and Death <b>3 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D41968</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael D. Martin, MD. 1576 Merrett Blvd. Baltimore, MD 21222</b>									
31. Date filed (Month, Day, Year) <b>07 1996</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13389

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albina</b>				2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1996</b>				3. Time of Death <b>12:45a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Rossville</b>				4c. County of Death <b>Baltimore county</b>	
Funeral Director	5. Social Security Number <b>216-32-5976</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 1, 1937</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	10a. State <b>Md.</b>				10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>315 Grovethorn Road</b>				10f. Zip Code <b>21220</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>own home</b>				17. Father's Name (First, Middle, Last) <b>Frank J. Rott</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Annie J. Cizler</b>				19a. Informant's Name/Relationship (Type, Print) <b>Ernest McCauley</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2010 Holly Neck Road Baltimore Md. 21221</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 5/9/96</b>				20c. Location - City or Town, State <b>Baltimore Md.</b>	
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>VENTRICULAR Fibrillation</b> Due to (or as a consequence of): b. <b>EXTENSIVE ANTERIOR MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): c. <b>ARTERIOSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>1 Hour</b> <b>2 WEEKS</b> <b>YEARS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Kenneth B. Lewis, MD</b>		
29c. License number <b>DO 5751</b>				29d. Date signed (Month, Day, Year) <b>May 7, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kenneth B. Lewis, MD, 910 Franklin Sq Dr, Baltimore, Md 21237</b>		
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>				32. Registrar's Signature <b>[Signature]</b>				33. Registrar's Title <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

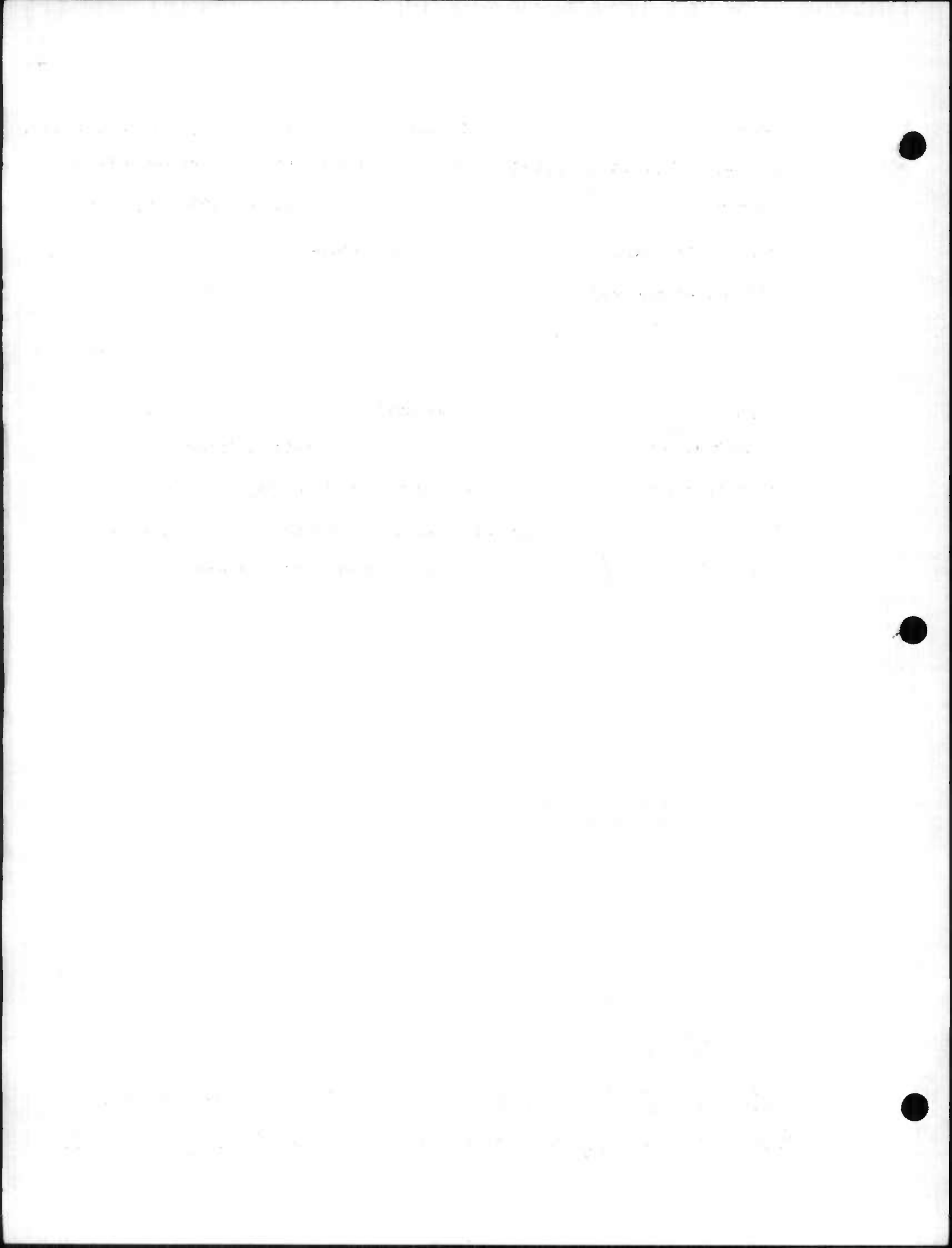
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13390

Item: 21 per F.H. G-735 5/7/96 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

COLLIS MCMILLAN

2. Date of Death

Day Year  
05 02 1996

3. Time of Death

3.30 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

240-32-3084

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 8, 1926

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yea 2 ☐ No

10e. Street and Number

2527 Seamon Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

-

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

18b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Sandy McMillan

18. Mother's Name (First, Middle, Maiden Surname)

Nicey Ann Smith

19a. Informant's Name/Relationship (Type, Print)

Betty McMillan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2527 Seamon Avenue, Baltimore, MD 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Cemeety

Date

5-6-96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Bill Jackson

22. Name and Address of Facility

March F.H. 1101 E. North Ave., Balto., MD 21202

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

MULTIPLE CEREBROVASCULAR ACCIDENTS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

Harbor Hospital

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 8 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Maya Thomas INTERN

29c. License number

2441614-32

29d. Date signed (Month, Day, Year)

05-02-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYA T. KOTTARATHIL

3001 S. HANOVER STREET  
BALTIMORE, MD-21225State  
Registrar

31. Date filed (Month, Day, Year)

MAY 07 1996

Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13391

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANDREW E. NAUMANN</b>				2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>08:15A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-26-2635</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/01/1929</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Halethorpe</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1816 Mayfield Ave.</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>52-54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> Collega (1-4or 5+) <input type="checkbox"/>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Warehouse</b>		
17. Father's Name (First, Middle, Last) <b>William Naumann</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Wright</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Louise Ferrera Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1816 Mayfield Ave. Baltimore, Md 21227</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		Data <b>5/9/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>5 Minutes</b> <b>10 Years</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D44362</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Enrico A. Giangeruso St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



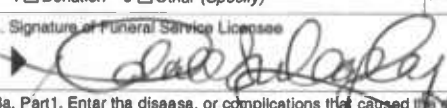


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13392

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anthony James Nelson, Jr.</b>					2. Date of Death Month Day Year <b>May 2, 1996</b>		3. Time of Death <b>6:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3061 -A Mower Court</b>					4b. City, Town, or Location of Death <b>Ft. Meade</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>103-72-7138</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>16</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 8, 1979</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Ft. Meade</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3061-A Mower Court</b>					10f. Zip Code <b>20755</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>			16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>Anthony J. Nelson, Sr.</b>					18. Mother's Name (First, Middle, Maiden Sumame) <b>Marian Rountree</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Anthony J. Nelson, Sr./Father</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3061-A Mower Court, Ft. Meade, Maryland 20755</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore-Washington Cr.</b>		Data <b>5/3</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acquired Immune Deficiency Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									Approximate Interval Between Onset and Death <b>18 month</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number <b>168122-1</b>		29d. Date signed (Month, Day, Year) <b>May 3<sup>rd</sup> 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daniel Goldberg, 40 Dept of Reg. Welfare Work D.C.</b>									
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a is marked other than "natural", or item 23b is marked other than "natural", the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13393

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CECELIA A. OLSZEWSKI				2. Date of Death Month Day Year MAY 03, 1996		3. Time of Death 10:39PM		
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 216 18 4475		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1916	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 856 North Shore Drive				10f. Zip Code 21060		10g. Citizen of What Country? U.S.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bar Maid		16b. Kind of Business/Industry Bar				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Theodore J. Becker				18. Mother's Name (First, Middle, Maiden Surname) Margaret M. Faulk				
	19a. Informant's Name/Relationship (Type, Print) Edward Lowery				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 Pennington Avenue Baltimore, Maryland 21226				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Date 5/7/96		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee <i>Jerome Znamenski</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Ischemic Heart Disease Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4/96 85 85	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Circosis 4/96 Right Hemiparesis from Stroke 83						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dr. Harold G. Hebard</i>		29c. License number D31144		29d. Date signed (Month, Day, Year) 5-5-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. HAROLD G. HEBARD, M.D. 1600 CRAIN HIGHWAY, SW #208 GLEN BURNIE, MD 21061									
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature <i>Johia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 1. PER F.H. FILM G-735

State of Maryland / Department of Health and Mental Hygiene

96 13394

5/7/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RALPH LINDEN PERRY JUNIOR JR.</b>				2. Date of Death Month <b>MAY</b> Day <b>4th</b> Year <b>1996</b>		3. Time of Death <b>11:45 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER 3001, SOUTH HANOVER STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE City</b>	
Funeral Director	5. Social Security Number <b>218 14 7716</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 27, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10e. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Linthicum</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent <b>416 Hillview Drive Apt. 304</b>				10f. Zip Code <b>21090</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W. II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+) <b></b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Driver</b>		16b. Kind of Business/Industry <b>Arundel Corp.</b>			
	17. Father's Name (First, Middle, Last) <b>Ralph L. Perry Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna L. Lemmon</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Gordon Perry</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5824 Redmond Street Baltimore, Maryland 21225</b>			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Memorial, Crematorium, etc.) <b>Meadowridge Memorial Park</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20f. Date <b>5/7/96</b>	
	21. Signature of Funeral Service Licensee <i>Donna M. Zanicovich</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>			
	23e. Part I. Enter the disease, and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. NON-SMALL CELL LUNG CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>b. Due to (or as a consequence of):</b>  <b>c. Due to (or as a consequence of):</b>  <b>d. Due to (or as a consequence of):</b>							
	23f. Approximate Interval Between Onset and Death <b>8 MONTHS</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Usha Srihari</i> <b>RESIDENT INTERNAL MEDICINE</b>				29c. License number <b>ASS2441614-25</b>		29d. Date signed (Month, Day, Year) <b>MAY 4th 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>USHA SRIHARI VEMULA KONDA 3001, SOUTH HANOVER STREET, BALTIMORE, MD 21225</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <i>John Shuckor-Randall</i>						




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13395

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Virginia E. Parker</b>					2. Date of Death Month Day Year <b>May 4 1996</b>		3. Time of Death <b>2:30 am.</b>													
	4a. Facility Name (If not Institution, give street and number) <b>Westminster Nursing &amp; Convalescent Ctr. Westminster Carroll</b>					4b. City, Town, or Location of Death		4c. County of Death													
Funeral Director	5. Social Security Number <b>215-07-8062</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>Oct. 26, 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>												
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number <b>1901 Lang Rd.</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>U.S.A.</b>														
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>U.S. Government</b>														
	17. Father's Name (First, Middle, Last) <b>Alexander Henry Parker</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Virginia Harris</b>															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>J. Thomas Lewis- Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1901 Lang Rd. Hampstead, Md. 21074</b>																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 5-6-1996</b>		Date		20c. Location - City or Town, State <b>Baltimore, Md.</b>														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Renal failure</u></td> <td>Due to (or as a consequence of):</td> <td>4 days</td> </tr> <tr> <td>b. <u>Hypertensive cardiovascular disease</u></td> <td>Due to (or as a consequence of):</td> <td>20 years</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. <u>Renal failure</u>	Due to (or as a consequence of):	4 days	b. <u>Hypertensive cardiovascular disease</u>	Due to (or as a consequence of):	20 years	c. _____	Due to (or as a consequence of):		d. _____	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <u>Renal failure</u>	Due to (or as a consequence of):	4 days																		
	b. <u>Hypertensive cardiovascular disease</u>	Due to (or as a consequence of):	20 years																		
	c. _____	Due to (or as a consequence of):																			
	d. _____	Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebrovascular accident</u> <u>Seizure disorder</u>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred												
			26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			26f. Location (Street and Number or Rural Route Number, City or Town, State)															
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D17040</b>		29d. Date signed (Month, Day, Year) <b>05-06-96</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Howard G. Lanham, M.D. 215 Wash Hgts Med Ctr, Westminster, MD 21157</b>																					
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

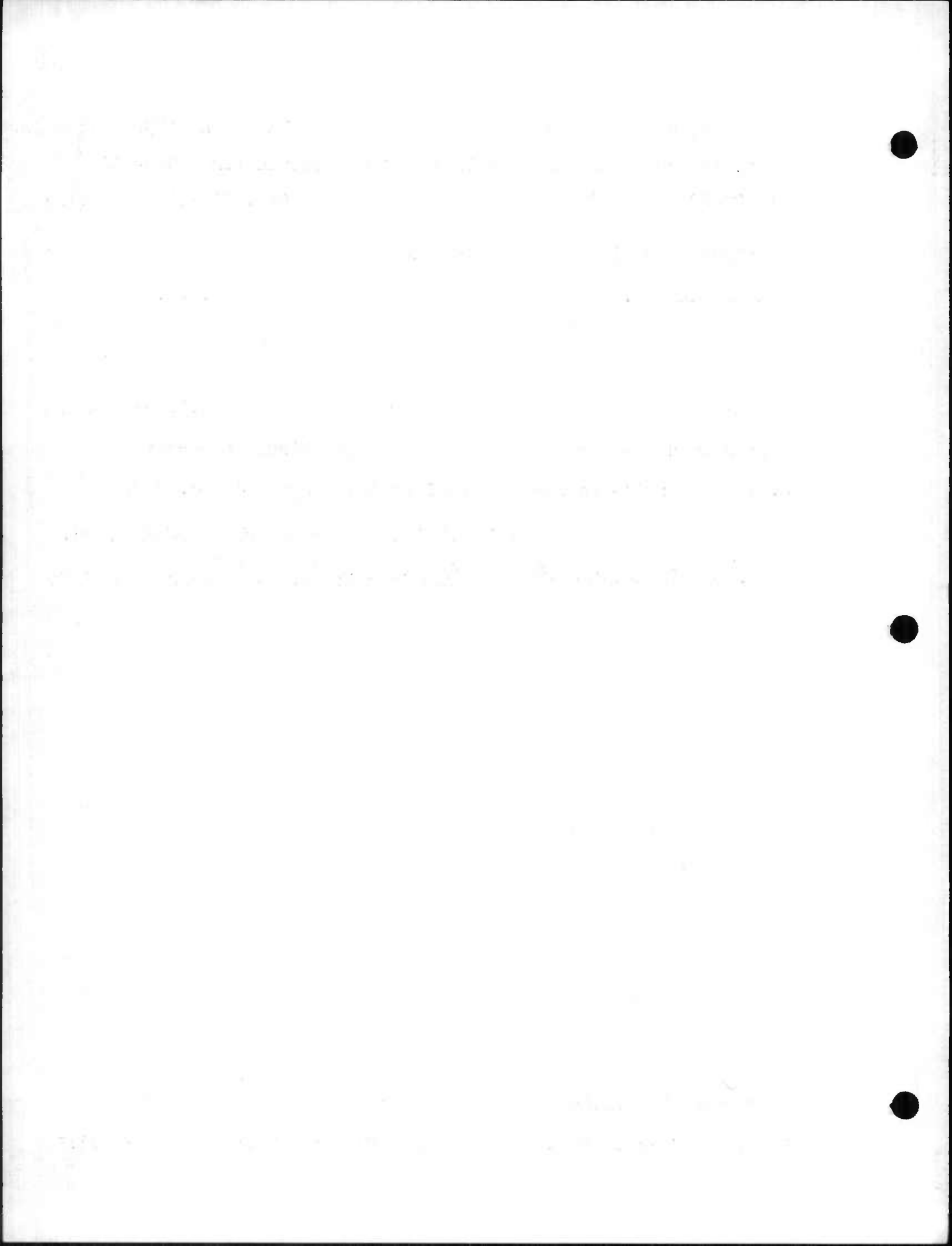
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLORINE E. PARKER</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>3</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2330 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-20-3946D</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 25, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>n/a</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1516 PENTRIDGE ROAD</b>			
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WAITRESS</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RESTAURANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BOLDIE DAVIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH FERGUSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LINDA PARKER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1426 WALKER AVE., BALTIMORE, MD 21239</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL CEM. 5-8</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley B. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary disease</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Phil Boesch MD</i>				29c. LICENSE NUMBER <b>MD 5895</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/3/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Phil Boesch MD, Union Memorial, Balto. MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13397

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patrick John Quinn				2. DATE OF DEATH MONTH DAY YEAR May 4 1996 0115 M		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER 360-22-6401		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 4, 1930	
8. BIRTHPLACE (State or Foreign Country) Illinois				9. CITY, TOWN OR LOCATION OF DEATH Annapolis		10. COUNTY OF DEATH Anne Arundel	
11. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				12. CITY, TOWN OR LOCATION OF DEATH Annapolis		13. COUNTY OF DEATH Anne Arundel	
14. STATE MD		15. COUNTY Anne Arundel		16. CITY, TOWN OR LOCATION Edgewater		17. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
18. STREET AND NUMBER 1600 Riverdale Drive				19. ZIP CODE 21037		20. CITIZEN OF WHAT COUNTRY? USA	
21. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Photographer		27. KIND OF BUSINESS/INDUSTRY Industrial			
28. FATHER'S NAME (First, Middle, Last) Patrick J. Quinn				29. MOTHER'S NAME (First, Middle, Maiden Surname) Alice McShane			
30. INFORMANT'S NAME (Type/Print) Mary Quinn Raynor				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 South 90th, Omaha, NE 68124			
32. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		34. DATE 5/7		35. LOCATION — City or Town, State Baltimore, MD	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patrick J. Quinn</i>				37. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>acute renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		45. DESCRIBE HOW INJURY OCCURRED	
46. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		47. SIGNATURE AND TITLE OF CERTIFIER <i>Robert T. Peterson</i>		48. LICENSE NUMBER 124804		49. DATE SIGNED (Month, Day, Year) 5-4-96	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T. Peterson 600 Ridgely Ave Annapolis Md 21401							
51. DATE FILED (Month, Day, Year) MAY 07 1996		52. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13398

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine E. Rigby</b>				2. Date of Death Month <b>May</b> 2, Day <b>1996</b> Year		3. Time of Death <b>5:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Summit Nursing Home</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-22-2409</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <b>Feb. 15, 1905</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>402 Bloomsbury Avenue</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+) +1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>		16b. Kind of Business/Industry <b>medical</b>		
17. Father's Name (First, Middle, Last) <b>William George Finkner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian R. Schmidt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rose Smith, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 Bloomsbury Avenue Catonsville, MD 21228</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		e. <b>Cardiorespiratory Failure</b> Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. <b>ASCD - Senility</b> Due to (or as a consequence of):						
		c. <b>Alzheimer's Disease.</b> Due to (or as a consequence of):						
		d.						
Approximate Interval Between Onset and Death		days. yrs. yrs.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe osteoarthritis.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>D.P. Malayalam, MD</b>		29c. License number <b>D18396</b>		29d. Date signed (Month, Day, Year) <b>5-3-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4001 Wilkens Ave, Baltimore MD 21229</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 						

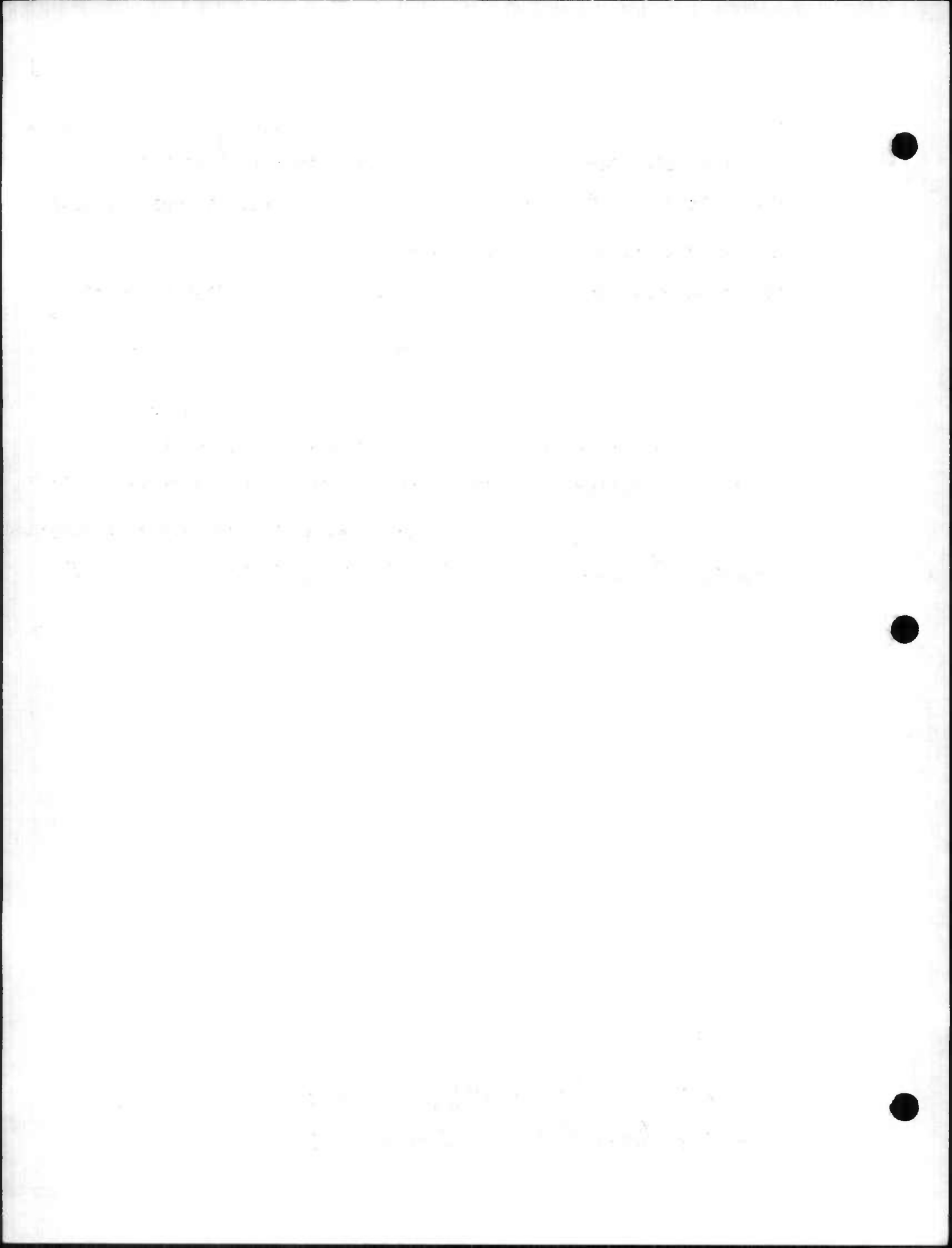
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13399

## Certificate of Death

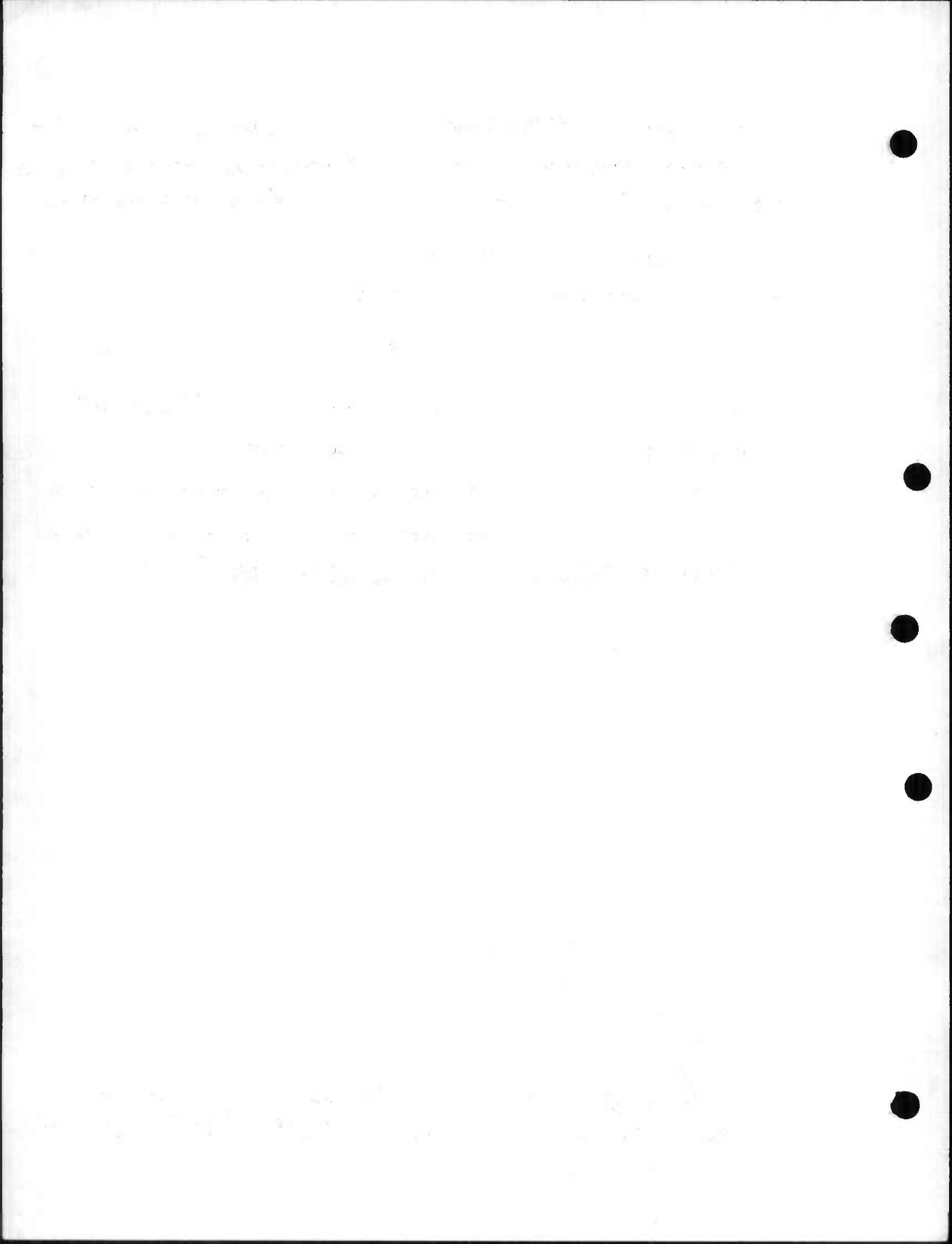
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH RAMSEY</b>				2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>642 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE MARYLAND</b>	
Funeral Director	5. Social Security Number <b>189-12-0311</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 18, 1917</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>n/a</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>3909 Southern Cross Drive</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Shot Sheet Smelting Copper</b>		16b. Kind of Business/Industry <b>American Smelting Refinement Company</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>David E. Ramsey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Carrington</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Irene Ramsey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3909 Southern Cross Drive Baltimore, MD 21207</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date <b>May 7th</b>		20c. Location - City or Town, State <b>Baltimore County, MD</b>	
	21. Signature of Funeral Service Licensee <b>Gay L. Folmer</b>		22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>NON-INSULIN DEPENDENT DIABETIC MELLITUS</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>36%</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HISTORY OF OLD MYOCARDIAL INFARCTION</b> <b>NON-INSULIN DEPENDENT DIABETIC MELLITUS</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>MD</b>		29c. License number <b>D19502</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, 1996</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ORLANDO B. CANTANAN MD. NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD. 21133</b>							
	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>Madson-Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13400

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE MAE RICHARDSON

2. Date of Death

APRIL 28 1996

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTO. CITY

5. Social Security Number

267 30 7062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9/15/16

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10e. State

MD.

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3901 FLOWERSTON RD.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WILLIE BRUNSON

18. Mother's Name (First, Middle, Maiden Surname)

LIZA T. BRUNSON

19a. Informant's Name/Relationship (Type, Print)

WILLIENE RICHARDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3901 FLOWERTON RD. BALTO. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK 5/4/96

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

*Kamal K. Dang*

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 Eutaw PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

30 mins.

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

1 hour

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE CARDIOVASCULAR DISEASE

INSULIN DEPENDANT DIABETE MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

NA

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how Injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Kamal K. Dang*

29c. License number

D18362

29d. Date signed (Month, Day, Year)

APRIL 28, 1996.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KOMAL K. DANG M.D. 3455, Wilkens Ave. Balto. Md 21229.

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

*Davidson-Randall*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13401

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Hannah Nancy Reahl</i>						2. Date of Death Month <i>May</i> Day <i>5</i> Year <i>1996</i>		3. Time of Death <i>0035</i>	
	4a. Facility Name (If not institution, give street and number) <b>MERCY MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <i>219-30-8682</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>68</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <i>6-29-1927</i>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>							
Usual Residence of Decedent										
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>4102 ST. PAUL STREET</b>				10f. Zip Code <b>21218</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>				16b. Kind of Business/Industry <b>HOMEMAKER</b>		
17. Father's Name (First, Middle, Last) <b>JAMES L. SCHANBERGER</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARGUERITE McCLOSKEY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>G. EDWARD REAHL JR.</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4102 ST. PAUL ST. BALTO., MD. 21218.</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM.</b>		Data <b>5/8/96</b>		20c. Location - City or Town, State <b>TIMONIUM, MD.</b>		
21. Signature of Funeral Service Licensee <i>William R. Jenkins</i>						22. Name and Address of Facility <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Thoracic Spine fracture (T6)</i> Due to (or as a consequence of): <i>b. Complicated by Bronchectasis</i> Due to (or as a consequence of): <i>c. With Complications</i> Due to (or as a consequence of): <i>d.</i>										
Approximate Interval Between Onset and Death										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Respiratory failure, Septic shock,</i> <i>Chronic Pseudomonas pulmonary infection</i>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>April 9, 1996</i>		28b. Time of Injury <i>~830A</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <i>Fell down steps</i>		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Steps @ home</i>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>4102 ST. Paul ST Balto MD</i>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Michael Bond</i>						29c. License number <i>P09129</i>		29d. Date signed (Month, Day, Year) <i>May 5, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael Bond 301 ST. Paul place Baltimore MD 21202</i>										
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>										
32. Registrar's Signature <i>Davidson</i>										

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**CERTIFICATE OF DEATH** REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma Anna Scheibe</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>4</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>5:25 P.</b>			
4. SOCIAL SECURITY NUMBER <b>212 03 1792</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>87</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 11, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>					
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>613 Hammonds Lane</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>D.M.V.A.</b>					
17. FATHER'S NAME (First, Middle, Last) <b>August S. Freund</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ann Thomas</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Hilda S. Freund</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Baltimore Avenue Ferndale, Maryland 21061</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		DATE <b>5/9</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Zimowski</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy., Baltimore, Md. 21225</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Myocardial Infarction</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>b. Essential Hypertension</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c.</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b> <b>Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate interval Between Onset and Death <b>1 day</b>  <b>8 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harjit Singh MD.</i> (Attending Physician)						29c. LICENSE NUMBER <b>D14160</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 6, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96-13403

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ROBERT EDWARD SMITH</b>				2. Date of Death Month <b>MAY</b> Day <b>05</b> Year <b>96</b>		3. Time of Death <b>3:21 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>1300 PONTIAC AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>218-46-9145</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 16, 1947</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1300 PONTIAC AVE.</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WELDER</b>		16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>BENJAMIN SMITH</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>RUTH (UNKNOWN)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>DOROTHY NICHOLS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1300 PONTIAC AVENUE BALTIMORE, MARYLAND 21225</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC.</b>		20c. Date <b>5/7/96</b>		20d. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>GONCE FUNERAL HOME P.A. 4001 RITCHIE HIGHWAY BALTIMORE, MD. 21225</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>PULMONARY THROMBOEMBOLISM</b> Due to (or as a consequence of): <b>LEFT LEG INJURY</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>7 Months</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>10/21/95</b>		28b. Time of Injury <b>2:30 PM</b>		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred <b>Pipe fell on subject</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>6211 Pennington Ave., Balt.</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>07/02/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R. Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>Reissued: 07/02/96</b>		32. Registrar's Signature  <b>JUL 19 1996</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Page 123

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

2. It is essential to ensure that all data is entered correctly and that the system is updated regularly.

3. The second part of the document outlines the procedures for handling customer inquiries and complaints.

4. It is important to respond to customers promptly and to provide them with the information they need.

5. The third part of the document describes the various methods used to collect and analyze data.

6. It is necessary to use a variety of techniques to ensure that the data is reliable and valid.

7. The fourth part of the document discusses the importance of maintaining the confidentiality of the data.

8. It is essential to implement strong security measures to protect the data from unauthorized access.

9. The fifth part of the document outlines the procedures for archiving and backing up the data.

10. It is important to ensure that the data is stored securely and that it can be recovered in the event of a disaster.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 13404

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Clarence Scott</b>					2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>6:45 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>250-01-4726</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/19/1916</b>		9. Birthplace (State or Foreign Country) <b>S. Carolina</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2504 Sycamore Avenue</b>				10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Repairman</b>			16b. Kind of Business/Industry <b>In Home</b>		
17. Father's Name (First, Middle, Last) <b>Mann Brown</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ida B. Scott Walton</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Josie M. Bradford</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>254 Mt. Pleasant Ave., Newark, NJ 07104</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>5/6</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVE. BALTO. 21207</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death <b>10 Hours</b>
Immediate Cause (Final disease or condition resulting in death) e. <b>Gastrointestinal Hemorrhage</b> Due to (or as a consequence of):									
b. <b>Gastric Carcinoma</b> Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic melanoma</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>96002</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. Conroy, M.D.</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Johns Hopkins Bayview Medical Center 4940 Eastern Avenue, Baltimore, MD 21224</b>						
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13405

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <i>Viola Edwards Spencer</i>				2. Date of Death Month <i>April</i> Day <i>30</i> Year <i>1996</i>				3. Time of Death <i>0319 am</i>			
4a. Facility Name (If not institution, give street and number) <i>Snai Hosp 2901 Belvedere Ave</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Baltimore</i>			
5. Social Security Number <i>219-10-5898</i>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>70</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec 20, 1925</i>		9. Birthplace (State or Foreign Country) <i>Virginia</i>			
10a. State <i>Maryland</i>				10b. County <i>n/a</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2960 Mosher Street Apt. 4B</i>				10f. Zip Code <i>21216</i>				10g. Citizen of What Country? <i>USA</i>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>1</i> College (1-4 or 5+) <i>1</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Inspector</i>				16b. Kind of Business/Industry <i>Velvetone Cleaners</i>			
17. Father's Name (First, Middle, Last) <i>Carroll Edwards</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Carrie Turner</i>					
19a. Informant's Name/Relationship (Type, Print) <i>James Edwards (son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>33 Saddlestone Court Owings Mills, MD 21117</i>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i>				Date <i>May 4th</i>		20c. Location - City or Town, State <i>Baltimore County, MD</i>	
21. Signature of Funeral Service Licensee <i>Beun Parker</i>				22. Name and Address of Facility <i>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Anoxic Brain Injury</i> Due to (or as a consequence of): <i>b. s/p Cardiac Arrest</i> Due to (or as a consequence of): <i>c. Pneumonia</i> Due to (or as a consequence of): <i>d.</i>										Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Valeri Sera</i>				29c. License number <i>AS2402321 VS 9931</i>		29d. Date signed (Month, Day, Year) <i>April 30, 1996</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>2901 Belvedere Ave Baltimore, MD</i>											
31. Date filed (Month, Day, Year) <i>MAY 07 1996</i>				32. Registrar's Signature <i>Davidson</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13406

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD B. STELLMANN JR.				2. Date of Death Month Day Year MAY 02, 1996				3. Time of Death 8:15 PM					
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A					
Funeral Director	5. Social Security Number 220-24-3712		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 10-30-1927		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent													
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 6 UPLAND RD.				10f. Zip Code 21210				10g. Citizen of What Country? U.S.A.						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREA			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) C.E.O BIBB HEATING CO.				16b. Kind of Business/Industry HEATING CO.						
17. Father's Name (First, Middle, Last) EDWARD B. STELLMANN								18. Mother's Name (First, Middle, Maiden Surname) CAROLINE TICKNOR						
19a. Informant's Name/Relationship (Type, Print) SANDRA STELLMANN								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 UPLAND RD. BALTO., MD. 21210.						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT				Date 5/6/96		20c. Location - City or Town, State BALTO., MD.				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Immediate Cause (Final disease or condition resulting in death)												Approximate Interval Between Onset and Death		
e. Sepsis Due to (or as a consequence of):												3 days		
b. Pancreatic Adenocarcinoma Due to (or as a consequence of):												2 years		
c. Due to (or as a consequence of):														
d. Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred				
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number M9065				29d. Date signed (Month, Day, Year) May 2, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Chih Hur, 110 Tower, Johns Hopkins Hospital, Baltimore MD 21287														
31. Date filed (Month, Day, Year) MAY 07 1996				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13407

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Reed Smith</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>2023</b>	
	4a. Facility Name (If not institution, give street and number) <b>University Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>049-24-9897</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs., last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <b>Oct. 12, 1932</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2501 Brookfield Ave.</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Presser</b>		16b. Kind of Business/Industry <b>Dry Cleaners</b>		
17. Father's Name (First, Middle, Last) <b>Roy Payton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Payton</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Evelyn Thomas</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2501 Brookfield Ave., 2nd Floor Balto, Md. 21217</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. Date <b>5/11/96</b>		20d. Location - City or Town, State <b>Catonsville, Md.</b>		
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration</b> Due to (or as a consequence of): b. <b>Fatal Arrhythmia</b> Due to (or as a consequence of): c. <b>Probable Myocardial infarction</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>J. P. Sullivan</b>		29c. License number <b>D36557</b>		29d. Date signed (Month, Day, Year) <b>5/4/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eff D. Williamson M.D.</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13408

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Smith				2. Date of Death Month May 5, 1996 Year				3. Time of Death 6:49 P.M.	
	4a. Facility Name (If not Institution, give street and number) Northwest Hospital Center				4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 412-12-8110		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 8, 1912		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Reisterstown				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 124 High Falcon Rd.				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver				16b. Kind of Business/Industry Tennessee State Roads		
17. Father's Name (First, Middle, Last) William Henry Smith				18. Mother's Name (First, Middle, Maiden Surname) Mollie Dowdy						
19a. Informant's Name/Relationship (Type, Print) Gail Rada - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 High Falcon Rd. Reisterstown, Md. 21136						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Mem. Gardens 5-8-1996		Date 5-8-1996		20c. Location - City or Town, State Finksburg, Md.				
21. Signature of Funeral Service Licensee J. Hart Edhardt				22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death Hours										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Stroke</u> <u>Benign neurochemical synomycty</u>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Hart Edhardt		29c. License number D27123		29d. Date signed (Month, Day, Year) 5/6/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Hart Edhardt 750 main st Reisterstown, md 21136										
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature J. Hart Edhardt								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report

is devoted to a general

description of the

method used in the

investigation.

The results of the

investigation are

presented in the

following

table.

The data are

shown

in

the

figure.

The

results are

summarized in the

conclusion.

The

is

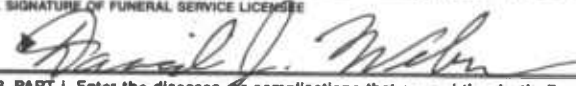
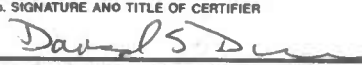

the

conclusion of the

96 13409

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Sumoski</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>1</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:16 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>217-07-0221</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/03/1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bel Forest Nursing &amp; Rehab. Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Forest Hill</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Forest Hill</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>109 Forest Valley Drive</b>			
10f. ZIP CODE <b>21050</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, OIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Factory</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wojciech Szumowski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Joann Wisniewska</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Estelle Balcerzak Sister</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4122 Perryview Rd Baltimore, Md 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		20c. DATE <b>5/4</b>		20d. LOCATION — City or Town, State <b>Baltimore, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>David J. Weber Funeral Home</b> <b>401 S. Chester St Baltimore, Md 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>&lt; 1 m</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>032259</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 2, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>615 W. MacPhail Rd David S. Dunn</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucy S. Stone</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>2</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>1035 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>229-20-8451</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 23, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Johns Hopkins Geriatrics Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Prince George</b>				10c. CITY, TOWN OR LOCATION <b>Laurel</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1126 12TH Street</b>			
10f. ZIP CODE <b>20707</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Walter Strum</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Cary Strum</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Carl Stone/Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1126 12TH Street, Laurel, Maryland 20707</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Way Hill Cemetery 5/6</b>		20c. LOCATION — City or Town, State <b>Laurel, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin J. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Polycythemia Vera</b> DUE TO (OR AS A CONSEQUENCE OF): <b>protein deficiency malnutrition</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sacral pressure ulcer</b> <b>Staphylococcal ulcer</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D24334</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 6, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas FINUCANE JHG C 5505 Hopkins Bayview Circle Baltimore, Maryland 21224</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13411

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dymond Jenea Stewart				2. Date of Death Month Day Year April 25, 1996		3. Time of Death 7:45 AM				
	4a. Facility Name (If not Institution, give street and number) Prince Georges Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George				
Funeral Director	5. Social Security Number N/A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 15 April 25, 1996		8. Date of Birth (Month, Day, Year) April 25, 1996		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Prince George		10c. City, Town or Location Greenbelt				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 7990 Lakecrest Drive				10f. Zip Code 20770		10g. Citizen of What Country? USA					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) N/A N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A				
17. Father's Name (First, Middle, Last) James Stewart					18. Mother's Name (First, Middle, Maiden Surname) Darlene Everett Stewart						
19a. Informant's Name/Relationship (Type, Print) Darlene Stewart/Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7990 Lakecrest Drive, Greenbelt, Maryland 20770						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Cr.		Date 5/2		20c. Location - City or Town, State Laurel, Maryland				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prematurity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number D31855		29d. Date signed (Month, Day, Year) 05/03/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Cynthia Sadler 7425 Forest Blvd., Lanham, Maryland 20706 #202											
31. Date filed (Month, Day, Year) MAY 07 1996											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13412

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose Marie SEITZ				2. Date of Death Month Day Year May 3, 1996		3. Time of Death 8:45 PM						
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 215-22-3028		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 18, 1920	9. Birthplace (State or Foreign Country) PA.					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 164 Wiltshire Road				10f. Zip Code 21221		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry own home								
	17. Father's Name (First, Middle, Last) Ignatious Rudinsky				18. Mother's Name (First, Middle, Maiden Surname) Mary Kotulak								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William Seitz				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 164 Wiltshire Road Baltimore Md. 21221								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 5/7/96		Date 5/7/96		20c. Location - City or Town, State Baltimore Md.						
	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial infarction</td> <td rowspan="4">Approximate interval Between Onset and Death 8 days</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	Approximate interval Between Onset and Death 8 days	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	Approximate interval Between Onset and Death 8 days											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left bundle branch block, bradycardia Hyponatremia Hypotension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jeffrey E. Astbury		29c. License number 047435 (MD)		29d. Date signed (Month, Day, Year) 5/3/96		30. Name and address of person who completed cause of death (Name, 25a) (Type, Print) Dr. Jeffrey Astbury 9000 Franklin Square Dr. Baltimore, Maryland 21237					
31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature Davidson-Randall											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13413

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irene Skazis

2. Date of Death

Month Day Year  
03 05 96

3. Time of Death

2:25PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Meridian Franklin Woods

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

235-16-0963

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 14, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Rossville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9200 Franklin Square Drive

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

18b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Pete Pappas

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Pitianos

19a. Informant's Name/Relationship (Type, Print)

Stanley Skazis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5640 Arnhem Road Baltimore Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greek Orthodox Cemetery

Date

5/8/96

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex  
300 Mace Ave. Baltimore Md. 2122123a. Part 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RHEUMATIC HEART DISEASE

Due to (or as a consequence of):

20 yrs.

b. MITRAL REGURGITATION

Due to (or as a consequence of):

15 yrs.

c. END STAGE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

3 mos.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ba Yin Oung

29c. License number

D17728

29d. Date signed (Month, Day, Year)

May 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ba Yin Oung, M.D. 8022 Belair Rd. Baltimore, MD 21236

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

Ba Yin Oung

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





## REPLACEMENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96-13414

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Roger Smith

2. Date of Death

Month Day Year  
April 30 1996

3. Time of Death

9:27 AM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-46-2872

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 24 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4807 Valley Forge Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
10 n/a

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Shipping/Hauling

17. Father's Name (First, Middle, Last)

Melvin Charles Smith

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Marie (Speed) Ryan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret M. Ryan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4807 Valley Forge Rd., Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gough United Meth.Ch.Cem.

Date

5/4/96

20c. Location - City or Town, State

Cockeysville, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiomyopathy with biventricular failure  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Nephrotic SyndromeDiabetes Mellitus Diet controlled with Nephropathy & Neuropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

T Kawaja

29c. License number

D25112

29d. Date signed (Month, Day, Year)

05/13/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tahoora Kawaja, M.D. 5310 Old Court Rd., Suite 305, Randallstown, MD 21208

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

John A. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

1. The first part of the report is devoted to a description of the general situation in the country. It is a very interesting and detailed account of the political and economic conditions. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country.

2. The second part of the report is devoted to a description of the social conditions. It is a very interesting and detailed account of the social conditions. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country.

3. The third part of the report is devoted to a description of the cultural conditions. It is a very interesting and detailed account of the cultural conditions. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country.

96 13415

Items: 9b, 16a per F.H. G-735 5/7/96 reb

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Naman Suber</b>		2. DATE OF DEATH MONTH <b>May</b> DAY <b>5</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4:41 A M</b>
4. SOCIAL SECURITY NUMBER <b>248-42-9146</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>70</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 25, 1925</b>	8. BIRTHPLACE (State or Foreign Country) <b>LAURENS, SC</b>
9a. FACILITY NAME (If not institution, give street and number) <b>MERCY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE (CEMETERY)</b>		9c. COUNTY OF DEATH <b>n/a</b>
10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1759 E. PRESTON STREET</b>		
10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>NAVY 10-44/4-46</b>	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 8+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STEELSIDE SEETSIDE LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BETHLEHEM STEEL CORP.</b>
17. FATHER'S NAME (First, Middle, Last) <b>ARTHUR SUBER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BERTHA WOODY</b>		
19a. INFORMANT'S NAME (Type/Print) <b>SHARRE JONES</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3101 FOUR SEASON COURT, BALTIMORE, MD 21222</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FR. CEMETERY 5-10</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory acidosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Chronic Obstructive Pulmonary Disease</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Deneen Pieri, MD</b>		29c. LICENSE NUMBER <b>D44377</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 5, 1996</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Deneen Pieri, MD 6320 Ritchie Highway, Suite 1 Glen Burnie, MD 21061</b>				
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE 		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1

61801 7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13416

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTHER TERRY</b>				2. Date of Death Month <b>May</b> Day <b>02</b> Year <b>1996</b>		3. Time of Death <b>3:00PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>5411 Hildenbrand Court</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>		
Funeral Director	5. Social Security Number <b>044-28-8707</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	II Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 18, 1898</b>	9. Birthplace (State or Foreign Country) <b>Rhode Island</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>5411 Hildenbrand Court</b>				10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Domestic</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Theodore Grant Darby</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Mary Brown</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Jean Doree Turnage</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5471 Hildenbrand Court Columbia, Md. 21044</b>				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from Site <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balt-Washington Crematory, Inc.</b>		Data <b>5-6-96</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		
	21. Signature of Funeral Service Licensee 		M00544		22. Name and Address of Facility <b>Slack Funeral Home, P.A. Ellicott City, Md. 21043</b>				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Dua to (or as a consequence of):  <b>b. </b> Dua to (or as a consequence of):  <b>c. </b> Dua to (or as a consequence of):  <b>d. </b>							Approximate Interval Between Onset and Death <b>1 Week</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Breast Cancer</b> <b>Hypernephroma</b> <b>Thyroid Cancer</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D32482</b>		
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>May 03, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lynn D. Alonso, MD 2 Knoll North Drive, Columbia Maryland 21045</b>		31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>				
	32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13417

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey Eugenia TARR</b>				2. Date of Death Month Day Year <b>May 3, 1996</b>		3. Time of Death <b>3:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220-12-9864</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 15, 1923</b>	9. Birthplace (State or Foreign Country) <b>United States</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>436 Torner Road</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>10th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cafeteria Worker</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Walter Raymond Costin Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rita Unknown Unknown</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Bruce Raymond Tarr -Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>436 Torner Road, Essex, Maryland-21221</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Crematory</b>		20c. Date <b>5/8/96</b>		20d. Location - City or Town, State <b>Towson, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Kathleen M. Murphy</b>				22. Name and Address of Facility <b>6415 Belair Road John C. Miller, Inc. Baltimore, Maryland-21206</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>EMPHYSEMA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>HYPERTENSION</b> <b>CORONARY ARTERY DISEASE</b>							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D31076</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>OKN ELIASSON M.D. 9105 Franklin Sq. Drive Bmrv, Md 21237</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

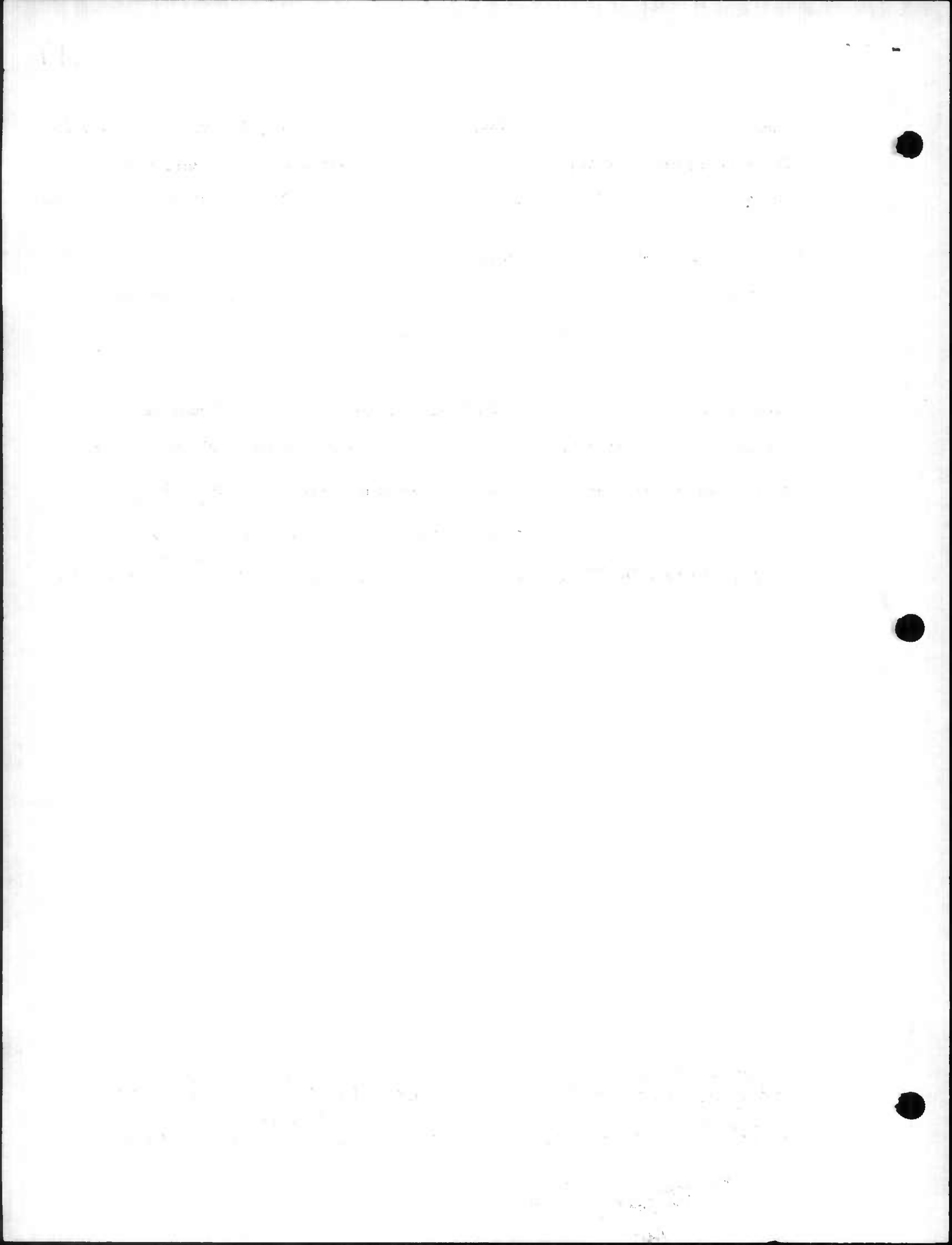
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13418

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA M

VOYCE

2. Date of Death

MAY 6 1996

3. Time of Death

845am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213 14 5558

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

228 Lake Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Line Leader

16b. Kind of Business/Industry

Calvert Dist.

17. Father's Name (First, Middle, Last)

William Soulsman

18. Mother's Name (First, Middle, Maiden Surname)

Clara Niederhouser

19a. Informant's Name/Relationship (Type, Print)

William Voyce

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 Lake Road

Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Cedar Hill Cemetery

Date

5/8/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard Gonce

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. INTRACEREBRAL hemorrhage

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

(Check only  
one)  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Agatha

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

May 6<sup>th</sup> 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cynthia DRETHLO, 301 HARBOR DRIVE, GLEN BURNIE MD 21061.

31. Date filed (Month, Day, Year)

MAY 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13419

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLOTTE VENABLE</b>				2. Date of Death Month <b>MAY</b> Day <b>4</b> , Year <b>1996</b>		3. Time of Death <b>2:55P</b>	
	4a. Facility Name (If not institution, give street and number) <b>1523 FRIENDSHIP ST.</b>				4b. City, Town, or Location of Death <b>21218</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-38-2026</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 12, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10e. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1523 FRIENDSHIP ST.</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAN</b>		16b. Kind of Business/Industry <b>HOPKINS UNIVERSITY</b>		17. Father's Name (First, Middle, Last) <b>LEAZAR BROOKS</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE DREW</b>		19a. Informant's Name/Relationship (Type, Print) <b>REGINALD VENABLE-HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1523 FRIENDSHIP ST. BALTO, MD. 21218</b>		20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEM. PK.</b>		20c. Date <b>MAY 10, 1996</b>		20d. Location - City or Town, State <b>BALTO, MD.</b>		21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i>	
	22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory failure</b> Due to (or as a consequence of): <b>Severe Sarcoidosis lungs</b> Due to (or as a consequence of): <b>Unresponsive to Prednisone</b> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD	
	29c. License number <b>DB2975</b>		29d. Date signed (Month, Day, Year) <b>5-6-96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Y.K. RAMAIAH MD 447N Keywood Ave</b>		31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar Signature <i>[Signature]</i>		33. Registrar Title <b>Registrar</b>		34. Registrar Address <b>1300 21218</b>		35. Registrar Phone <b>21218</b>	
	36. Registrar Signature <i>[Signature]</i>		37. Registrar Title <b>Registrar</b>		38. Registrar Address <b>1300 21218</b>		39. Registrar Phone <b>21218</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13420

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Annairene Whetzel</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>03</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>9:49p</i>			
4. SOCIAL SECURITY NUMBER <i>220-22-3052</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 31, 1927</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>			9c. COUNTY OF DEATH <i>N/A</i>		
RESIDENCE OF DECEDENT				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>8600 Sandy Plains Road</i>		10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>9 years</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>James Kowalewski</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Rajnish</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Donna M. Whetzel (Daughter)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8242 Kavanagh Road Dundalk, Maryland 21222</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Stanislaus Cemetery 5/7/96</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coigestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>digoxin toxicity</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>renal failure</i> Approximate Interval Between Onset and Death <i>1 year</i> <i>10 years</i> <i>1 week</i> <i>1 week</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Left arm fracture</i>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard C. Hui MD</i>				29c. LICENSE NUMBER <i>D43273</i>		29d. DATE SIGNED (Month, Day, Year) <i>May, 03/1996</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard C. Hui MD 600 N. Wolfe street, Baltimore MD 21045</i>									
31. DATE FILED (Month, Day, Year) <i>MAY 07 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25







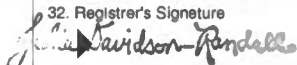
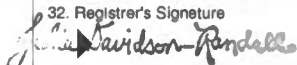
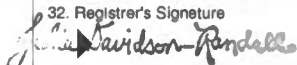
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13421

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARTIN L. WILLEY, Sr.</b>						2. Date of Death Month <b>MAY</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>11:52 AM</b>																															
	4a. Facility Name (If not institution, give street and number) <b>Bay View Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>																															
Funeral Director	5. Social Security Number <b>217 16 4748</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08 12 22</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>																															
	Usual Residence of Decedent																																							
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Eastwood</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
	10e. Street and Number <b>7112 Eastbrook Avenue</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>																																	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>W.W.2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>			16b. Kind of Business/Industry <b>Crown, Cork, Seal</b>																																
	17. Father's Name (First, Middle, Last) <b>George Hammond Willey</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Frazier</b>																																	
	19a. Informant's Name/Relationship (Type, Print) <b>Nellie, B. Willey, Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7112 Eastbrook Avenue Balto., Md. 21224</b>																																			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hills Cemetery</b>		Date <b>5-9-96</b>		20c. Location - City or Town, State <b>Middle River, Md.</b>																																	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave. Balto., Md.</b>																																			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																							
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>PNEUMONIA</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>DAYS</b></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>PNEUMONIA</b>	Approximate Interval Between Onset and Death <b>DAYS</b>	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):																				
Immediate Cause (Final disease or condition resulting in death)	a.	<b>PNEUMONIA</b>	Approximate Interval Between Onset and Death <b>DAYS</b>																																					
	b.	Due to (or as a consequence of):																																						
	c.	Due to (or as a consequence of):																																						
	d.	Due to (or as a consequence of):																																						
<table border="1"> <tr> <td colspan="6">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b></td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="6"></td> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>										Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																																
<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="8">28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury <b>M</b></td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="3">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>										25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																						
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		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																		
<table border="1"> <tr> <td colspan="2">29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td colspan="2">29b. Signature and title of certifier </td> <td colspan="2">29c. License number <b>96023</b></td> <td colspan="4">29d. Date signed (Month, Day, Year) <b>MAY 5 1996</b></td> </tr> </table>										29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>96023</b>		29d. Date signed (Month, Day, Year) <b>MAY 5 1996</b>																								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>96023</b>		29d. Date signed (Month, Day, Year) <b>MAY 5 1996</b>																																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VAHAN SHAHINIAN JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>																																								
<table border="1"> <tr> <td colspan="2">31. Date filed (Month, Day, Year) <b>MAY 07 1996</b></td> <td colspan="8">32. Registrar's Signature </td> </tr> </table>										31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 																												
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 																																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13422

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nellie Wilson</b>				2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>4:40A</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore, MD</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>219-28-5942A</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 1, 1906</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1825 North Dallas Street</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th Grade</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>Private Families</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Cephas</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Willie E. Branch</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Martha Ruffin (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2903 Rockwood Avenue Baltimore, Maryland 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Data <b>May 10</b>		20c. Location - City or Town, State <b>Baltimore County, MD</b>		
21. Signature of Funeral Service Licensee <b>Steven Parker</b>				22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. atherosclerotic vascular disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>D. Hays HOUSE OFFICER</b>				29c. License number <b>NILTS</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SARA HAYS, Johns Hopkins Hospital, Baltimore, MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>Wilson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

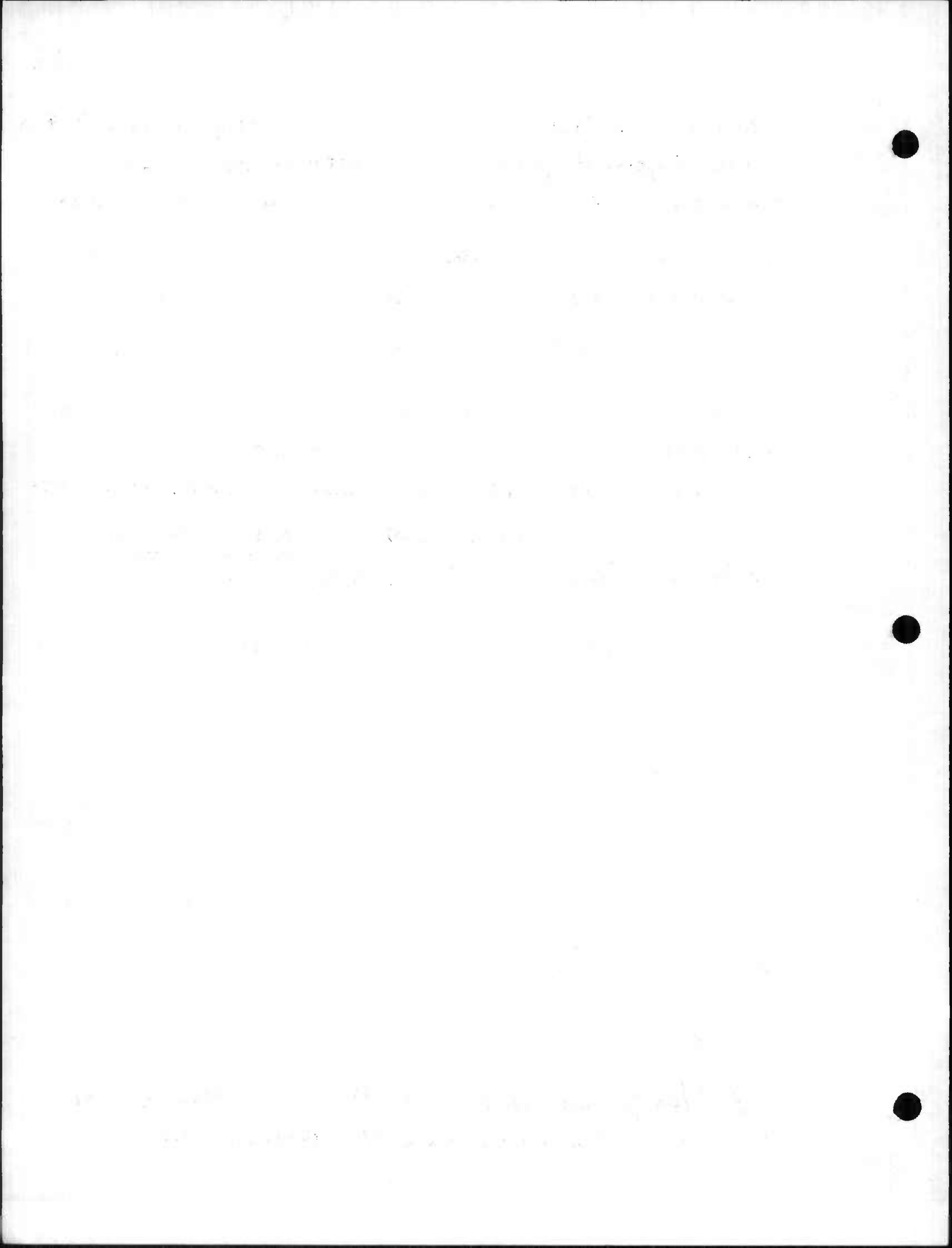
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13423

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Sophia L. Wilkins</u>				2. Date of Death Month <u>May</u> Day <u>06</u> Year <u>1996</u>		3. Time of Death <u>11:08 Am</u>	
	4a. Facility Name (If not institution, give street and number) <u>St. Agnes Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>	
Funeral Director	5. Social Security Number <u>220-30-0108</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>87</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Aug 19, 1908</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>146 North Denison Street</u>				10f. Zip Code <u>21229</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) <u>Grade School</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Domestic</u>		16b. Kind of Business/Industry <u>Private Families</u>		
17. Father's Name (First, Middle, Last) <u>James Dorsey</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Davis</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Madeline Hall (niece)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>607 64th Avenue Seat Pleasant, Maryland 20743</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arbutus Memorial Park</u>		Date <u>May 11</u>		20c. Location - City or Town, State <u>Baltimore County, MD</u>
21. Signature of Funeral Service Licensee <u>Harbert E. Nutter</u>				22. Name and Address of Facility <u>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. MASSIVE CEREBRO - VASCULAR ACCIDENT</u> Due to (or as a consequence of): <u>b. CHRONIC BRADY ARYTHMIAS</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <u>24 Hours</u> <u>3 YEARS</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC RENAL FAILURE</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>F. Ansah MD</u>				29c. License number <u>PD 9519</u>		29d. Date signed (Month, Day, Year) <u>MAY 06, 1996</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>ST AGNES HOSPITAL FRANCIS ANSAH MD 900 CATON AVE, BALTIMORE, MD 21229</u>								
31. Date filed (Month, Day, Year) <u>MAY 07 1996</u>				32. Registrar's Signature <u>[Signature]</u>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 13424

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE WATERS JR.</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>1</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>9:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218 58 7006</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/17/53</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SANDTOWN NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTO. CITY</b>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTO. CITY</b>		10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10e. STREET AND NUMBER <b>1918 N. PAYSON ST.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FURNITURE REPAIRMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LEVITZ FURNITURE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE WATERS SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DELORES PARKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DELORES PARKS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2441 DORTON CT. BALTIMORE, MD. 21230</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY 5/4/96</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE. MD.</b>		20d. DATE <b>5/4/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carl A. Estep</i>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A., 1300 EUTAW PL. BALTO. MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral Pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiomyopathy and Congestive heart failure</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>HIV AIDS</b> d. DUE TO (OR AS A CONSEQUENCE OF): <b>HIV</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Atteydy Physicia</i>				29c. LICENSE NUMBER <b>D20215</b>		29d. DATE SIGNED (Month, Day, Year) <b>S-4-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KARMA S. NAIR, MD 1190 West Northern Pkwy, Bttr. MD 21210</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13425

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charles William Walters, Sr.</i>				2. Date of Death Month <i>MAY</i> Day <i>3rd</i> Year <i>1996</i>		3. Time of Death <i>2047</i>	
	4a. Facility Name (If not Institution, give street and number) <i>Mercy Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>214-18-0231</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>73</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 28, 1922</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>409 S. Old North Point Road</i>				10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>5 years</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Self-Employed</i>		16b. Kind of Business/Industry <i>Produce &amp; Seafood</i>			
	17. Father's Name (First, Middle, Last) <i>Charles Walters</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Augusta Wilkenson</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Charles W. Walters, Jr. (Son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7246 River Drive Road Baltimore, Maryland 21219</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery</i>		Data <i>5/7/96</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Pneumonia</i> Due to (or as a consequence of):  b. <i>Lung Cancer</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypercalcemia</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>07230</i>		29d. Date signed (Month, Day, Year) <i>May 4, 1996</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bahador Momeni, MD Mercy Medical Center Baltimore, MD</i>								
31. Date filed (Month, Day, Year) <i>MAY 07 1996</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13426

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Weber</b>				2. Date of Death Month <b>Apr</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>8:20 A.M.</b>											
	4e. Facility Name (If not institution, give street and number) <b>Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>											
Funeral Director	5. Social Security Number <b>214-14-2915</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-03-1922</b>											
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Street and Number <b>2235 Eastern Ave</b>		10f. Zip Code <b>21231</b>											
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates: <b>42-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cobbler</b>		16b. Kind of Business/Industry <b>Shoe Repair</b>													
	17. Father's Name (First, Middle, Last) <b>Michael Weber</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Catherine Grabowski</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>Debra Weber-Roark Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24354 Widgeon Place St. Michaels, Md 21663</b>													
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount</b>		20c. Date <b>5/3/96</b>		20d. Location - City or Town, State <b>Baltimore, Md</b>											
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Congestive Heart Failure</b></td> <td>Approximate Interval Between Onset and Death <b>5 yrs</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Myocardial Insufficiency</b></td> <td><b>7 yrs</b></td> </tr> <tr> <td>c. <b>Coronary Heart Disease</b></td> <td><b>15 yrs</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death <b>5 yrs</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Myocardial Insufficiency</b>	<b>7 yrs</b>	c. <b>Coronary Heart Disease</b>	<b>15 yrs</b>	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death <b>5 yrs</b>															
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Myocardial Insufficiency</b>	<b>7 yrs</b>															
		c. <b>Coronary Heart Disease</b>	<b>15 yrs</b>															
d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Plural Effusion</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Melvin Welinsky M.D.</b>		29c. License number <b>D-27921</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Melvin Welinsky 3411 Bank St. Baltimore, Maryland</b>																		
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <i>[Signature]</i>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


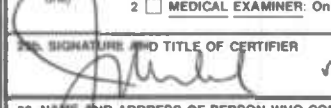

State  
Registrar



96 13427

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARSHALL PURNELL YERBY</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>1</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>1905</b> M	
4. SOCIAL SECURITY NUMBER <b>228-34-4602</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 28 1931</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>DEATON MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		10e. STREET AND NUMBER <b>4815 Midline Road</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1</b> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> Widowed <b>4</b> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>5th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LONGSHOREMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STEAMSHIP TRADE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ALFRED YERBY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LELA TAYLOR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joyce A. Yerby/Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4815 Midline Rd. Baltimore, Maryland 21206</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 5/7</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PROSTATE CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> YES <b>2</b> NO	
28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D38675</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 13428

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann R. Young</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>7:30 A.</b>	
	4a. Facility Name (If not institution, give street and number) <b>8511 Westford Road</b>				4b. City, Town, or Location of Death <b>Lutherville</b>		4c. County of Death <b>Baltimore County</b>	
Funeral Director	5. Social Security Number <b>159-14-2204</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 08, 1907</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lutherville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8511 Westford Road</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5+</b>			18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Church Office</b>		
	17. Father's Name (First, Middle, Last) <b>Elmer Reimel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Unknown</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Patricia Beneckson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8511 Westford Road, Lutherville, Maryland 21093</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>5/6</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Lyman Burgee-Henss</i>				22. Name and Address of Facility <b>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Conjunctive heart failure -</b> Due to (or as a consequence of): <b>old age</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Approximate interval between Onset and Death <b>3 mo</b>							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>John Mann</i>				29c. License number <b>057259</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John Mann 10755 Falls Rd Ste 200 Lutherville, MD 21093</b>							
	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <i>Lisa Davidson-Henderson</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13429

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVA M. AYERS</b>				2. Date of Death Month <b>MAY</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>8:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Levindale Nursing Home</b>				4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>220-14-6087</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 24, 1907</b>	9. Birthplace (State or Foreign Country) <b>md</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>		10b. County <b>NIA</b>		10c. City, Town, or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3240 Yosemite Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>NIA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.) <b>Domestic Worker</b>		16b. Kind of Business/Industry <b>Private Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Samuel Morris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Thompson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lois C. Henry - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1400 E. Madison Street Balto, md 21205</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>5-9-96 Randallstown, md</b>		20d. Date	
	21. Signature of Funeral Service Licensee <b>Sala March</b>		22. Name and Address of Facility <b>March A.H. West 4300 Wabash Ave Balto, md 21215</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>PNEUMONIA</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STATUS POST SUB-DURAL HEMATOMA</b>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>SET HTWAR ATTENDING PHYSICIAN</b>				29c. License number <b>D 25610</b>		29d. Date signed (Month, Day, Year) <b>MAY 5 - 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>LEVINDALE 2434 W. BELVERDERE AVENUE BALTIMORE MD 21215</b>							
	31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature <b>Sala March-Randall</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13430

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brenda M. Antlitz				2. Date of Death Month Day Year May 6, 1996		3. Time of Death 2:30pm	
	4a. Facility Name (If not Institution, give street and number) 1405 E. Clement Street				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-36-3775		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 7, 1940	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10a. Street and Number 1405 E. Clement Street				10f. Zip Code 21230		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Clerical			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Max Staffa				18. Mother's Name (First, Middle, Maiden Summa) Evelyn F. Farrell			
	19a. Informant's Name/Relationship (Type, Print) Joseph P. Antlitz / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 E. Clement Street, Baltimore, Maryland 21230			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Have Cem.		Date May 09, 1996	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. BREAST CANCER Due to (or as a consequence of): b. BRAIN METASTASIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1 YR.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D 31650	29d. Date signed (Month, Day, Year) 5/6/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN GUTHEIL 22 S. GREENE ST. BALTO. MD. 21201								
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

06

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13431

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON L. ANDREWS

2. Date of Death

Month

Day

Year

MAY

3

1996

3. Time of Death

5 25 PM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

215-07-2893

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 29, 1915

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6713 Alter St.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1941-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Frederick Andrews

18. Mother's Name (First, Middle, Maiden Surname)

Estelle P. Rickerton

19a. Informant's Name/Relationship (Type, Print)

Ruth Andrews

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6713 Alter St. Baltimore, MD 21207

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Service 5/7/96 Hampstead, MD

Date

5/7/96

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown, RD

Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. THALAMIC INFARCTION

Due to (or as a consequence of):

b. PNEUMONIA (RIGHT LOWER LOBE)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OLD CEREBROVASCULAR ACCIDENT

CERVICAL SPINE STENOSIS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation☐ Accident ☐ Could not be determined☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27157

29d. Date signed (Month, Day, Year)

MAY, 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND DEPESTRE

NORTH WEST HOSPITAL CENTER

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

96-2230-510  
AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13432

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT L BENNETT				2. Date of Death Month Day Year APRIL 24, 1996		3. Time of Death 21:55 P	
	4a. Facility Name (If not Institution, give street and number) SHOCK TRAUMA UNIT				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 430-42-2941		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04/04/53	9. Birthplace New York - New York
	Usual Residence of Decedent							
10a. State MD		10b. County N/A n/a		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 575 Lauren Street				10f. Zip Code 21217		10g. Citizen of What Country?		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Life Lite		
17. Father's Name (First, Middle, Last) Amos Bennett					18. Mother's Name (First, Middle, Maiden Surname) Rosalie Jones			
19a. Informant's Name/Relationship (Type, Print) Jennette Bennett				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 Lauren St. Balto. MD 21217				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 5/4/96	20c. Location - City or Town, State Baltimore		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Redd Funeral Services 1721-27 N. Monroe St. Balto. MD 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries with complications Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 4-10-96		28b. Time of Injury 0040 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Pedestrian struck by car
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 W. North Ave Baltimore City MD		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) APRIL 25, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13433

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY R. BROWN				2. Date of Death Month Day Year MAY 1, 1996		3. Time of Death 10:25 AM		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 215-36-4796		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) OCT. 1, 1898	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SANDY SPRING			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 513 OLNEY-SANDY SPRING ROAD				10f. Zip Code 20860		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) CHARLES CRAVER				18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA MYERS				
	19a. Informant's Name/Relationship (Type, Print) SARAH VIRGINIA BROWN, DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 OLNEY-SANDY SPRING ROAD, SANDY SPRING, MD. 20860				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHN'S CEMETERY		Data 5/3/96		20c. Location - City or Town, State OLNEY, MARYLAND		
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MARYLAND 20882				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. HYPOSTATIC PNEUMONIA Due to (or as a consequence of): b. CARDIOKYPATHY, CONGESTIVE Due to (or as a consequence of): c. A.S.C.V. D. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Approximate Interval Between Onset and Death 2 WKS 3 MONTHS 4 YRS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Donald R. Lewis MD				29c. License number D06406		29d. Date signed (Month, Day, Year) MAY 1, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD R. LEWIS MD RT108 OLNEY, MD 20832									
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar  
DHMH 16 Rev 6/95





96 13434

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DRUE WILLIE BEVERLY</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>7</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:15 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-28-9161</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 14 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1614 RUXTON AVENUE</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHNNY KILGORE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAMIE HUGHEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CATHY GARDENER/Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1614 RUXTON AVENUE, BALTIMORE, MARYLAND 21216</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CROWNSVILLE VETERANS 5/13 CROWNSVILLE, MARYLAND</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ischemic Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>3 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert McKinney, D.O.</b>				29c. LICENSE NUMBER <b>AT2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/7/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT MCKINNEY UNION MEMORIAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 13435

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sr. Mary Edith Burke R.S.M.				2. DATE OF DEATH MONTH DAY YEAR May 5, 1996		3. TIME OF DEATH 2:30 P M	
4. SOCIAL SECURITY NUMBER 220-54-8881		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/14/1907	
8. BIRTHPLACE (State or Foreign Country) WV.				9a. FACILITY NAME (If not institution, give street and number) The Villa 6806 Bellona Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE MD.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6806 Bellona Ave	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Religious Sisters		16b. KIND OF BUSINESS/INDUSTRY Religion	
17. FATHER'S NAME (First, Middle, Last) Charles E. Burke				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Graney			
19a. INFORMANT'S NAME (Type/Print) Sisters of Mercy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Bellona Ave. Baltimore, MD. 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 5/8		20c. LOCATION — City or Town, State Woodlawn, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Pete S. Ashman				22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Marcia Kane MD				29c. LICENSE NUMBER 026391		29d. DATE SIGNED (Month, Day, Year) 5/6/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marcia Kane MD 301 St. Paul Place Baltimore Md 21202							
31. DATE FILED (Month, Day, Year) MAY 08 1996				32. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

3

RECEIVED



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 13436

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN F. BARRETT				2. Date of Death Month Day Year MAY 06, 1996		3. Time of Death 6:55 PM.		
	4a. Facility Name (If not institution, give street and number) 1535 RAMSEY ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-30-6987		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/15/1934	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent								
10a. State MD.		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1535 Ramsey St.				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paralegal Secretary			16b. Kind of Business/Industry Law		
17. Father's Name (First, Middle, Last) Roy Earl Barrett				18. Mother's Name (First, Middle, Maiden Surname) Julia Magdeline					
19a. Informant's Name/Relationship (Type, Print) Earl Barrett / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 E. 37th St. Balto. MD. 21223					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 5/8/96		20c. Location - City or Town, State Beltsville, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Balto. MD. 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 07, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 08 1996			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13437

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jaquetta M. Bailey</i>					2. Date of Death Month <i>May</i> Day <i>3</i> Year <i>1996</i>		3. Time of Death <i>10:15 PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>1681 Woodbourne Avenue</i>					4b. City, Town, or Location of Death <i>Balto</i>		4c. County of Death <i>NIA</i>		
Funeral Director	5. Social Security Number <i>214-27-0393</i>		6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>11</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <i>Aug 19, 1984</i>		9. Birthplace (State or Foreign Country) <i>md</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>md</i>		10b. County <i>NIA</i>		10c. City, Town or Location <i>Balto</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>1681 Woodbourne Ave</i>				10f. Zip Code <i>21239</i>		10g. Citizen of What Country? <i>U.S.A</i>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5th</i> College (1-4or 5+) <i>NIA</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Student</i>			16b. Kind of Business/Industry <i>school</i>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Conway T. Bailey</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Felder</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Conway T. Bailey - Father</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3109 Ripple Rd Balto, md 21244</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <i>Garrison Forest</i>		20c. Date <i>5/6/96</i>		20d. Location - City or Town, State <i>Owing Mills, md</i>			
	21. Signature of Funeral Service Licensee <i>Glynn B. Harris</i>					22. Name and Address of Facility <i>March F. H. - West 4300 Wabash Ave Balto, MD 21215</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>BRAIN STEM GLIOMA (TUMOR/CANCER)</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>11 MONTHS</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>Paul Fisher</i>				29c. License number <i>D47071</i>		29d. Date signed (Month, Day, Year) <i>5/7/96</i>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>DR PAUL FISHER HARVEY 811 THE JOHNS HOPKINS HOSPITAL BALTIMORE MD 21287</i>									
	31. Date filed (Month, Day, Year) <i>MAY 08 1996</i>		32. Registrar's Signature <i>John Anderson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13438

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLARENCE T. BOONE</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>12:37 P</b>	
	4a. Facility Name (If not Institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-09-1682</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 27, 1912</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>508 N. BRICE STREET</b>			10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN 9</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SHIPPING &amp; RECEIVING</b>		16b. Kind of Business/Industry <b>BAKERY</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HARRISON BOONE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ETTA (MN-BANNISTER)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BOBYETTA COOPER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1955 W. LEXINGTON ST., BALTIMORE, MD. 21223</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		Date <b>5-9-96</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Intracerebral Hemorrhage</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURES</b> <b>HISTORY OF ADENOCARCINOMA OF COLON</b>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>D. Shamsuddin MD</b>		29c. License number <b>D20252</b>	
	29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. SHAMSUDDIN 20 CROSSROADS DR. DWINGS MILLS MD 21117</b>							
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 13439

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE L BISHOP</b>				2. Date of Death Month Day Year <b>MAY 2, 1995</b>		3. Time of Death <b>12:55PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>A. A. COUNTY</b>	
Funeral Director	5. Social Security Number <b>214-20-1100</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 3, 1908</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>A. A. COUNTY</b>		10c. City, Town or Location <b>SEVERN</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>785 QUEENSTOWN ROAD</b>				10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>USA.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH GRADE</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DAY CARE WORK</b>		16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>		
17. Father's Name (First, Middle, Last) <b>JOSEPH CARROLL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH MARSHALL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN SMITH</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5104 QUEENSBURY AVE., BALTIMORE, MD, 21225</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST CEMETERY</b>		20c. Location - City or Town, State <b>5-7-96 OWINGS MILLS, MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute myocardial infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5/3/96</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ER</b>				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>91P508</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES WU, M.D. 1600 CRAIN HWY, SW #306, GLEN BURNIE, MD 21061</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to a discussion of the

theoretical aspects of the problem.

2. In the second part, we shall consider the experimental results

obtained in the course of the investigation.

3. The third part of the paper is devoted to a discussion of the

conclusions of the investigation.

4. Finally, we shall give a brief summary of the results.

5. The first part of the paper is devoted to a discussion of the

theoretical aspects of the problem.

6. In the second part, we shall consider the experimental results

obtained in the course of the investigation.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13440

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carrie Marie Bond				2. Date of Death Month Day Year May 5, 1996				3. Time of Death 10:00 A.M.	
	4a. Facility Name (If not institution, give street and number) Lakeside Manor Nursing Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-01-1325D	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/9/1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 17 Belhaven Drive				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Harry Scott				18. Mother's Name (First, Middle, Maiden Surname) Carrie Mary Thomas					
	19a. Informant's Name/Relationship (Type, Print) Caleb Robert Scott Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Belhaven Drive Baltimore, Maryland 21236					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery		Date 5/9/1996		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee <i>Theodore J. Dippel</i>				22. Name and Address of Facility The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206					
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic coronary artery disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Peripheral vascular disease</i>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Marion C. Kowalewski</i>				29c. License number D21022			29d. Date signed (Month, Day, Year) 5-6-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marion C. Kowalewski MD, 8604 Harford Road Baltimore, Maryland 21234										
31. Date filed (Month, Day, Year) May 08 1996										
32. Registrar's Signature <i>Marion C. Kowalewski</i>										

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



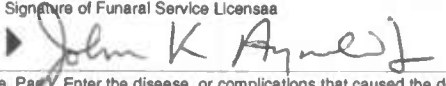
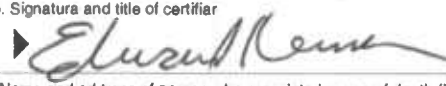
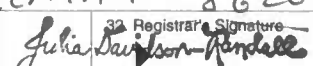
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13441

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARTHUR M. CHITTENDEN</b>				2. Date of Death Month Day Year <b>MAY 4, 1996</b>		3. Time of Death <b>4 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>3218 Shelburne Rd.</b>				4b. City, Town, or Location of Death <b>Pikesville</b>		4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>220-44-4431</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 18, 1897</b>			
	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Pikesville</b>			
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3218 Shelburne Rd.</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1919-</b> If Yes, Give Year or Dates: <b>1921</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Letter Carrier</b>		16b. Kind of Business/Industry <b>Post Office</b>						
17. Father's Name (First, Middle, Last) <b>Frederick Chittenden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Mae (Unknown)</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Ruth Shelton Goodman (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3218 Shelburne Rd. Pikesville, MD 21208</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Immanuel Lutheran Cem.</b>		20c. Location - City or Town, State <b>5-7-96 Baltimore City, MD</b>						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</b>						
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number <b>D19171</b>		29d. Date signed (Month, Day, Year) <b>5-6-96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Edward Sherman 8620 Liberty Plaza Mall 21133</b>										
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13442

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles CAIN, Sr.				2. Date of Death Month Day Year May 1, 1996		3. Time of Death 11:45p.m.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore county	
Funeral Director	5. Social Security Number 161-18-4510	6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) 09/09/1914	9. Birthplace (State or Foreign Country) West VA			
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3102 Hiss Avenue				10f. Zip Code 21234		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Daniel Cain				18. Mother's Name (First, Middle, Maiden Surname) Evaline Rhine				
19a. Informant's Name/Relationship (Type, Print) Ama Cain / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 Hiss Ave. Baltimore, MD 21234				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 5/4/96 Beltsville, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Rd. Dundalk, MD 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Myocardial ischemia Due to (or as a consequence of): b. Acidosis, Electrolyte disorder Due to (or as a consequence of): c. Bowel obstruction, dehydration Due to (or as a consequence of): Metastatic prostatic cancer d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Type 1 diabetes, myocardial infarction, congestive heart failure								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 019926		29d. Date signed (Month, Day, Year) 5/2/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Stang MD; Dept of E.M., Franklin Sq. Hosp. 9700 Franklin Sq. Dr. Palletta, MD. 21237								
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

3+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13443

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE B. CRIST</b>				2. Date of Death Month <b>MAY</b> Day <b>02</b> Year <b>96</b>		3. Time of Death <b>6:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GEN. HOSP.</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>220-01-5860</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/12/1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2893 Rosemar Drive</b>				10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanical Engineer</b>		16b. Kind of Business/Industry <b>Myerhoff Co.</b>		
17. Father's Name (First, Middle, Last) <b>George Bruce Crist</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Geesey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wife - Inge E. Crist</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2893 Roseman Drive, Ellicott City, Md. 21043</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Frederick, Md.</b>
21. Signature of Funeral Service Licensee <b>G. Truman Schwab</b>				22. Name and Address of Facility <b>G. Truman Schwab Funeral Home P.A. 5151 Balto. Natl. Pike, Baltimore, Md. 21229</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of): <b>Perforated Right Colon Cancer</b> Due to (or as a consequence of): <b>Carcinomatous, Ascites</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>One Week</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>James KIRAN PARKER</b>				29c. License number <b>D 26830</b>		29d. Date signed (Month, Day, Year) <b>May, 3, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4801 Dorsey Hall Dr, Suite 222, Ellicott City, Md. 21042</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature <b>John Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13444

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELMER B CARROLL</b>				2. Date of Death Month <b>5</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>15:46</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-20-4284</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 11, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1411 Washington Blvd</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>SELF</b>			
	17. Father's Name (First, Middle, Last) <b>CHARLES W. CARROLL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE M. HESS</b>		19a. Informant's Name/Relationship (Type, Print) <b>CHARLOTTE M. CARROLL</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1411 Washington Blvd Baltimore MD 21230</b>	
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		Date <b>5-8-96</b>		20c. Location - City or Town, State <b>Baltimore MD</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Raymond C. Fink Funeral Home</b> <b>436 Cedar Hwy SW Glen Burnie MD 21061</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PULMONARY HEMORRHAGE</b> Due to (or as a consequence of): <b>LUNG CARCINOMA</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
Medical Certification: To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kennita R. Carter, MD</b>		29c. License number <b>P09728</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KENNITA R. CARTER, M.D. 22 S. Greene St. Baltimore MD 21201</b>		31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <b>[Signature]</b>			
	33. Date of Death (Month, Day, Year)		34. Registrar's Signature		35. Date of Death (Month, Day, Year)		36. Registrar's Signature	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANITA COFFEE				2. Date of Death Month Day Year MAY 3, 1996		3. Time of Death 10:09AM																																					
	4a. Facility Name (If not Institution, give street and number) 1446 MOUNTMOR COURT				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																																					
Funeral Director	5. Social Security Number 220-80-1880	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	8. Date of Birth (Month, Day, Year) 11-26-61	9. Birthplace (State or Foreign Country) MD																																							
	Usual Residence of Decedent																																											
To Be Completed by Funeral Director	10a. State MD	10b. County	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																						
	10e. Street and Number 1446 Mountmor Ct			10f. Zip Code 21217		10g. Citizen of What Country? USA																																						
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black																																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown		18b. Kind of Business/Industry Unknown																																						
	17. Father's Name (First, Middle, Last) William Coffee, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Thomas																																							
	19a. Informant's Name/Relationship (Type, Print) Mary Franklin - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 Booker Ct. Baltimore, Md. 21217																																							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 5-9-96 Baltimore, Md.																																							
	21. Signature of Funeral Service Licensee Ervin Carroll				22. Name and Address of Facility 1712 W. North Ave. Baltimore, Md.																																							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																											
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. NARCOTIC INTOXICATION</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. NARCOTIC INTOXICATION							Due to (or as a consequence of):							b. Due to (or as a consequence of):							c. Due to (or as a consequence of):							Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Immediate Cause (Final disease or condition resulting in death)	e. NARCOTIC INTOXICATION																																											
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	c. Due to (or as a consequence of):																																											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																												
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																												
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND: 5-3-96		28b. Time of Injury FOUND: 10:00 A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																						
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE				28d. Describe how injury occurred UNKNOWN																																								
28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MARYLAND																																												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																												
29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 4, 1996																																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201																																												
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature [Signature]																																								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13446

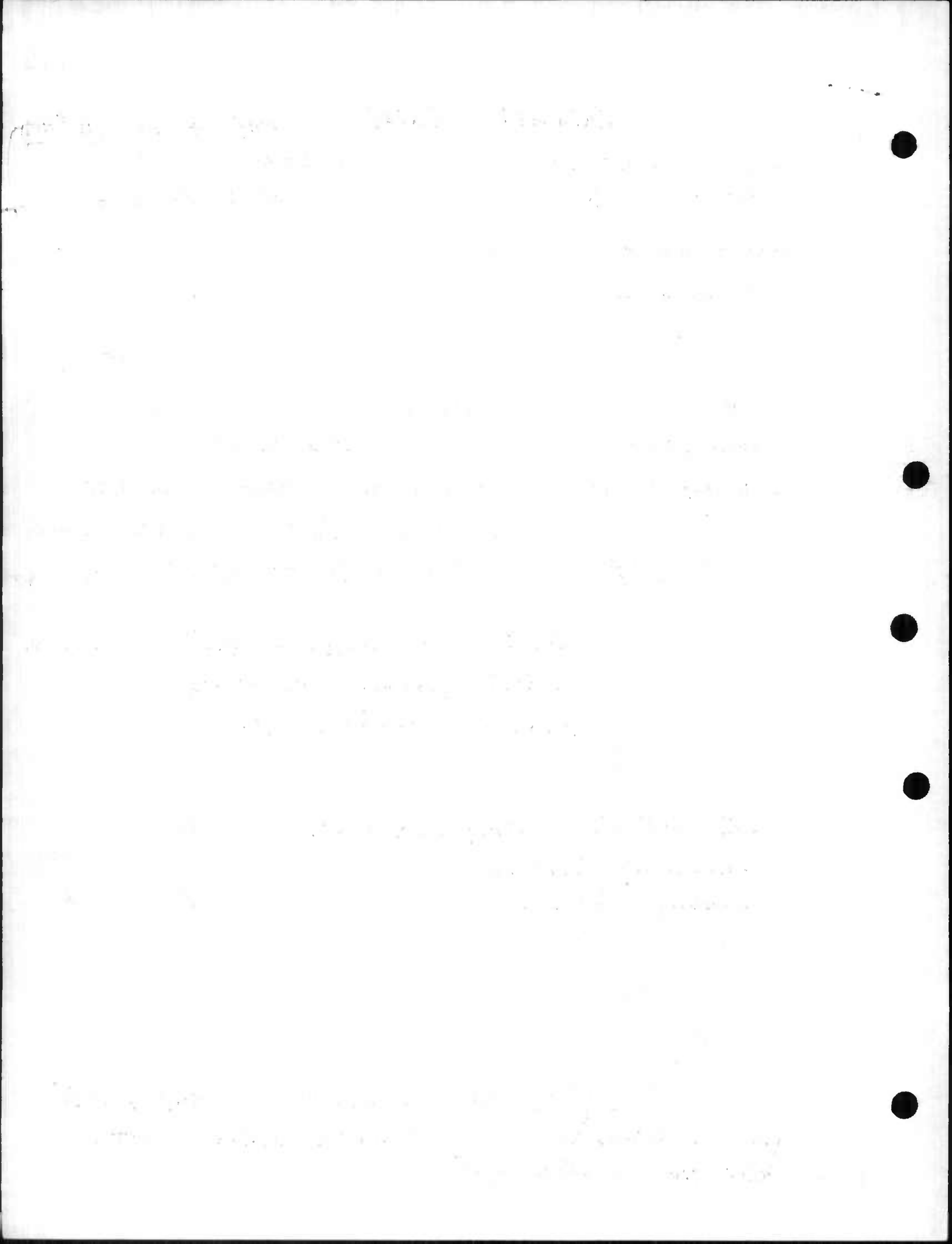
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHLEEN CAVEY</b>				2. Date of Death Month <b>MAY</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>11 30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-40-9370</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 13, 1943</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5947 Sunset Avenue</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Geneologist</b>		16b. Kind of Business/Industry <b>Research</b>		17. Father's Name (First, Middle, Last) <b>Raymond W. Burton</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen T. Tull</b>		19a. Informant's Name/Relationship (Type, Print) <b>Ralph Cavey (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5947 Sunset Avenue Baltimore, Maryland 21228</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Date <b>May 6, 1996</b>		20d. Location - City or Town, State <b>Catonsville, Maryland</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>SEPSIS (STAPHYLOCOCCUS AUREUS)</b> Due to (or as a consequence of): <b>DIABETES MELLITUS TYPE II</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>12 Hour</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier  MD		29c. License number <b>D 27157</b>		29d. Date signed (Month, Day, Year) <b>MAY, 4-1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAYMOND DEFEISTRE NORTHWEST HOSPITAL CENTER</b>		
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 		State Registrar		15		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



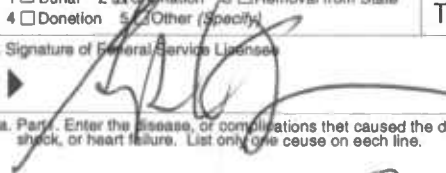


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13447

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Delos Charles DUPREE</b>				2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>2:45 A.M.</b>		
	4e. Facility Name (If not institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince Georges</b>		
Funeral Director	5. Social Security Number <b>399-09-6939</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 12, 1920</b>		
	9. Birthplace (State or Foreign Country) <b>Michigan</b>		10a. State <b>Md.</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Elkridge</b>		
Usual Residence of Decedent		10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6002 Hunt Club Rd.</b>		10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>U. S. Government</b>		17. Father's Name (First, Middle, Last) <b>Phillip Dupree</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Frieda Beaver</b>		19a. Informant's Name/Relationship (Type, Print) <b>Martha E. Dupree - wife</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6002 Hunt Club Rd., Elkridge, Md. 21227</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>The Green Mount Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		20d. Date <b>5/09/96</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>		23a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of) <b>b. Complete stroke with long</b> Due to (or as a consequence of) <b>c. Hypertension</b> Due to (or as a consequence of) <b>d.</b>		Approximate Interval Between Onset and Death <b>one week</b> <b>years</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D13339</b>	
29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tsunie Chanchien MD, 8824 Cunningham Drive, Berwyn Heights, MD 20740</b>		31. Date filed (Month, Day, Year)		32. Registrar's Signature 		33. Date of Death <b>May 6, 1996</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

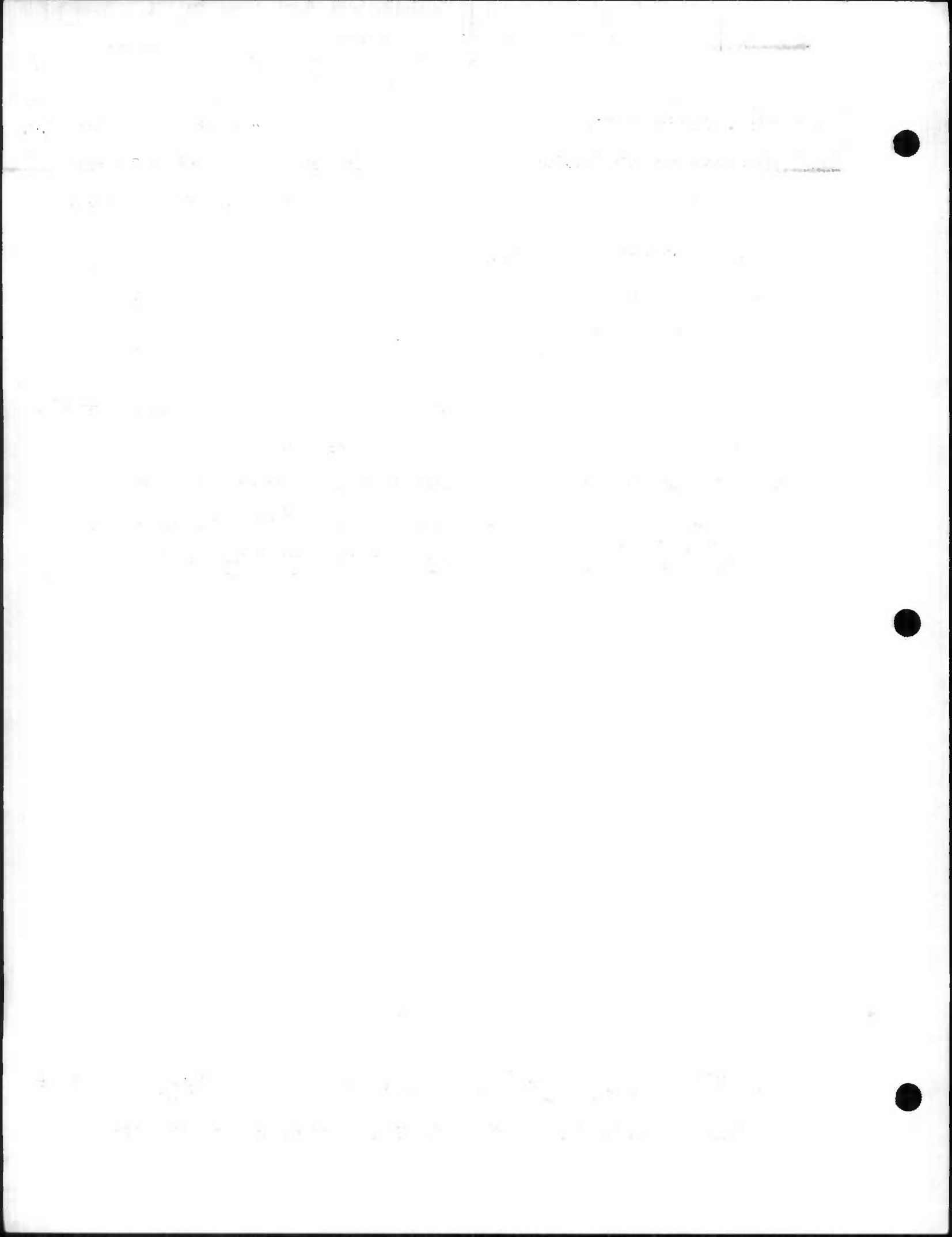
To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Certificate of Death

Reg. No.

96 13448

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMILY G. DAVIS				2. Date of Death Month Day Year MAY 5, 1996		3. Time of Death 10:15PM		
	4a. Facility Name (If not institution, give street and number) CHESAPEAKE MANOR EXTENDED CARE CENTER				4b. City, Town, or Location of Death ARNOLD		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 083-20-3436		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 26, 1909	9. Birthplace (State or Foreign Country) BROOKLYN, NY	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location EDGEWATER		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10a. Street and Number 3164 ROLLING ROAD				10f. Zip Code 21037		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE Collega (1-4or 5+) COLLEGE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		18b. Kind of Business/Industry HOMEMAKING				
	17. Father's Name (First, Middle, Last) RICHARD GRICE				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE SCHMIDT				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOYCE D. THAYER (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3164 ROLLING ROAD - EDGEWATER, MD. 21037				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLTOP SERVICE CORPORAT		Date 5/7/96		20c. Location - City or Town, State TOWSON		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Carcinoma of the Breast</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div> <p>Approximate interval Between Onset and Death</p> <p><u>17 years</u></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>C. V. Cyriac</u> Attending Doctor		29c. License number D21684		29d. Date signed (Month, Day, Year) 5-6-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. C. V. CYRIAC 1600 CRAIN HIGHWAY (SOUTH) - SUITE 106 - GLEN BURNIE, MD 21061									
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature <u>John A. Russell</u>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13449

Item 1, 17, Film 735, 5/8/96, 1t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHERINE P. DORSEY</b>				2. Date of Death Month: <b>05</b> Day: <b>06</b> Year: <b>1996</b>		3. Time of Death <b>10:00 AM</b>											
	4a. Facility Name (If not institution, give street and number) <b>PICKERSGILL RETIREMENT COMMUNITY</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>											
Funeral Director	5. Social Security Number <b>212-07-7391</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 05 1905</b>											
	9. Birthplace (State or Foreign Country) <b>Maryland</b>																	
Usual Residence of Decedent																		
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>615 Chestnut Ave.</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>												
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Clerical</b>											
17. Father's Name (First, Middle, Last) <b>JAMES JAMES Adam</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace R. Tracey</b>														
19a. Intment's Name/Relationship (Type, Print) <b>Pickersgill Retirement Home</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 Chestnut Ave. Towson, Md. 21204</b>														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>5-9-1996 Baltimore, Md.</b>												
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Sepsis syndrome</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>12 hours</b>   <b>1 day</b> </td> </tr> <tr> <td>b.</td> <td><b>pneumonia</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis syndrome</b>	Approximate Interval Between Onset and Death  <b>12 hours</b>  <b>1 day</b>	b.	<b>pneumonia</b>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis syndrome</b>	Approximate Interval Between Onset and Death  <b>12 hours</b>  <b>1 day</b>															
	b.	<b>pneumonia</b>																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide																		
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <b>Dr. Anthony Riley, MD</b>																		
29c. License number <b>025205</b>																		
29d. Date signed (Month, Day, Year) <b>5/6/96</b>																		
30. Name and address of person who completed cause of death (Item 22a) (Type, Print) <b>W. A. Riley, MD GBMC 6701 N. Charles Street, Towson, MD 21204</b>																		
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>																		
32. Registrar's Signature <b>John Davidson-Randall</b>																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

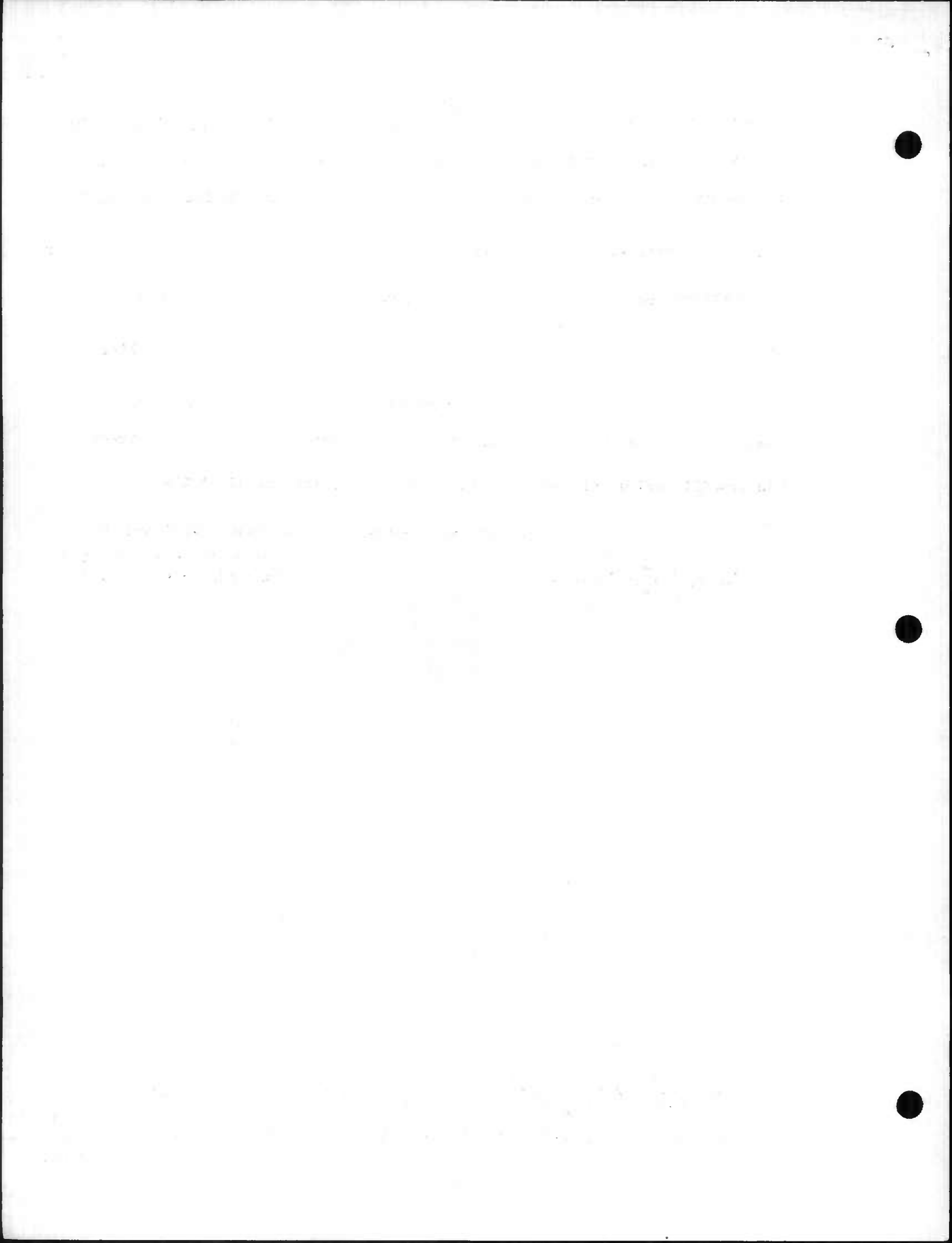
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13450

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Edward Dorsey</b>				2. Date of Death Month <b>5</b> Day <b>6</b> Year <b>96</b>		3. Time of Death <b>11:15 AM</b>										
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll County</b>										
Funeral Director	5. Social Security Number <b>219-14-8473</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 30, 1923</b>										
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Carroll County</b>		10c. City, Town or Location <b>Sykesville</b>										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7602 Norris Avenue</b>		10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>U.S.A.</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Janitorial</b>													
17. Father's Name (First, Middle, Last) <b>James Clifton Dorsey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Elizabeth Norris</b>													
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Agnes G. Dorsey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7602 Norris Avenue Sykesville, MD 21784</b>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Luke Cemetery</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>		20d. Date <b>5/9/96</b>											
21. Signature of Funeral Service Licensee <b>Brian R. Haight</b>				22. Name and Address of Facility <b>HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Electromechanical Dissociation</b></td> <td>Approximate Interval Between Onset and Death <b>30 min</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Hypoxemia</b></td> <td><b>30 min</b></td> </tr> <tr> <td>c. <b>Emphysema</b></td> <td><b>5 years</b></td> </tr> <tr> <td>d. <b>Old Anterior Myocardial Infarction</b></td> <td><b>4 years</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Electromechanical Dissociation</b>	Approximate Interval Between Onset and Death <b>30 min</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Hypoxemia</b>	<b>30 min</b>	c. <b>Emphysema</b>	<b>5 years</b>	d. <b>Old Anterior Myocardial Infarction</b>	<b>4 years</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>Electromechanical Dissociation</b>	Approximate Interval Between Onset and Death <b>30 min</b>															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Hypoxemia</b>	<b>30 min</b>															
	c. <b>Emphysema</b>	<b>5 years</b>															
	d. <b>Old Anterior Myocardial Infarction</b>	<b>4 years</b>															
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John Ricketts</b>		29c. License number <b>D39296</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. Ricketts MD CCGH Westminster MD 21157</b>																	
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		Registrar's Signature <b>John Ricketts</b>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

It is well known that this function is the arctangent function, i.e.  $f(x) = \arctan x$ . The main result of this section is the proof of the following theorem:

**Theorem 1.** Let  $f(x)$  be the function defined by the equation (1). Then for any  $x \in \mathbb{R}$  the following inequality holds:

$$|f(x)| \leq \frac{1}{2} \ln(1+x^2)$$

The proof of this theorem is given in the next section. In the third section we study the properties of the function  $f(x)$  for large values of  $x$ .

It is shown that for large values of  $x$  the function  $f(x)$  behaves like  $\frac{1}{2} \ln(1+x^2)$ . This result is used in the fourth section to study the asymptotic behavior of the function  $f(x)$  for large values of  $x$ .

In the fifth section we study the properties of the function  $f(x)$  for small values of  $x$ . It is shown that for small values of  $x$  the function  $f(x)$  behaves like  $x$ .

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State of Maryland / Department of Health and Mental Hygiene

96 13451

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John E. Davies Jr.</b>						2. Date of Death Month Day Year <b>May 6 1996</b>			3. Time of Death <b>10:05AM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>86 Yorkway Apt. A</b>						4b. City, Town, or Location of Death <b>N/A</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-20-6043</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		If Under 1 Year Montha Days		If Under 24 Hrs. Hours Min.		6. Date of Birth (Month, Day, Year) <b>Oct 12, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>N/A</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>86 Yorkway Apt. A</b>						10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Janitor</b>				16b. Kind of Business/Industry <b>Bowling Alley</b>			
	17. Father's Name (First, Middle, Last) <b>John E. Davies Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Helen L. Ziemann</b>					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Kenneth E. Davies/ brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1915 Midland Rd Baltimore, Md 21222</b>					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>5/8/96</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>			
	21. Signature of Funeral Service Licensee <i>Anthony Colt Connolly</i>						22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>b. CHRONIC OBSTRUCTIVE LUNG DISEASE</b> Due to (or as a consequence of): <b>c. PULMONARY TUBERCULOSIS</b> Due to (or as a consequence of): <b>d. MALNUTRITION</b>											
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier <b>Savinder Julka MD</b>						29c. License number <b>D27188</b>		29d. Date signed (Month, Day, Year) <b>5/7/96</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Savinder Julka, M.D. 2 Market Place Baltimore, Md 21222</b>											
	31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <i>Julia Davidson-Randall</i>									



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13452

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DERRICK M. Edmond</b>				2. Date of Death Month <b>5</b> Day <b>1</b> Year <b>96</b>		3. Time of Death <b>8 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1316 E. Coldspring Lane</b>				4b. City, Town, or Location of Death <b>BALTO. MD</b>		4c. County of Death <b>N.A.</b>	
Funeral Director	5. Social Security Number <b>219 90 4552</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9-30-65</b>	
	10a. State <b>MD</b>		10b. County <b>N.A.</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1316 E. Coldspring Lane</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11th Grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRANSPORTATION</b>		16b. Kind of Business/Industry <b>Good Samaritan Hosp</b>	
	17. Father's Name (First, Middle, Last) <b>John E. Edmond Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lydia M. Price</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lydia Edmond Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1316 E. Coldspring Lane BALTO. MD. 21239</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem PK</b>		20c. Location - City or Town, State <b>Arbutus. MD</b>		20d. Date <b>5/6/96</b>	
	21. Signature of Funeral Service Licensee <b>Joseph M. Locks Jr.</b>				22. Name and Address of Facility <b>Locks Funeral Home 1304 N. Central Ave</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pseudomonas Pneumonia</b> Due to (or as a consequence of): <b>b. Acquired Immune Deficiency Syndrome</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death <b>2 weeks</b> <b>10 years</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of injury (Month, Day Year)								
28b. Time of injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Thomas Wilson MD</b>								
29c. License number <b>D40277</b>								
29d. Date signed (Month, Day, Year) <b>5/3/96 May 3, 1996</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5601 Loch Raven Blvd Baltimore MD 21239</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>								
32. Registrar's Signature <b>Wilson-Randell</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 13453

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William H. England SR.					2. Date of Death Month Day Year May 6, 1996		3. Time of Death 8 41 pm													
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center					4b. City, Town, or Location of Death Baltimore		4c. County of Death													
Funeral Director	5. Social Security Number 217-38-0316		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 28 1939		9. Birthplace (State or Foreign Country) MARYLAND												
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State MD		10b. County AA Co.		10c. City, Town or Location GLEN BURNIE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number 631 Binsted Rd				10f. Zip Code 21060		10g. Citizen of What Country? USA														
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR			16b. Kind of Business/Industry SHOE MANUFACTURING													
	17. Father's Name (First, Middle, Last) GEORGE C. ENGLAND				18. Mother's Name (First, Middle, Maiden Summa) MILDRED LEIGHT																
	19a. Informant's Name/Relationship (Type, Print) ELIZABETH A. ENGLAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 BINSTED RD GLEN BURNIE MD 21060																
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Data 5-7-96		20c. Location - City or Town, State BALTIMORE MD														
	21. Signature of Funeral Service Licensee Thomas Shandaf				22. Name and Address of Facility Raymond C. Fink FUNERAL HOME 426 CERIN HWY SW GLEN BURNIE MD 21061																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sepsis</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Peritonitis</td> <td>Due to (or as a consequence of):</td> <td>2 days</td> </tr> <tr> <td>c. End stage liver disease</td> <td>Due to (or as a consequence of):</td> <td>2 days</td> </tr> <tr> <td>d. Hypertension</td> <td>Due to (or as a consequence of):</td> <td>4 years</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. Peritonitis	Due to (or as a consequence of):	2 days	c. End stage liver disease	Due to (or as a consequence of):	2 days	d. Hypertension	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death																		
	b. Peritonitis	Due to (or as a consequence of):	2 days																		
	c. End stage liver disease	Due to (or as a consequence of):	2 days																		
	d. Hypertension	Due to (or as a consequence of):	4 years																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal varices peptic ulcer disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier S. NAJJAR Senior Assistant Resident		29c. License number L9768		29d. Date signed (Month, Day, Year) 5/6/96															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. NAJJAR MD Tower 10 Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore MD 21237																					
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature James W. Anderson-Rendall																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13454

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN GEORGIA FEE				2. Date of Death Month Day Year APRIL 27 1996				3. Time of Death 3:15 A.M.	
	4a. Facility Name (If not institution, give street and number) 2019 EAST FAIRMOUNT AVENUE				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-18-2542		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 12, 1923		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2019 EAST FAIRMOUNT AVENUE				10f. Zip Code 21231		10g. Citizen of What Country? USA.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) CAROLL QUEEN				18. Mother's Name (First, Middle, Maiden Surname) GEORGIA WALKER					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) NEDRA GARDNER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 EAST FAIRMOUNT AVENUE, BALTIMORE, MD. 21231					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 5-2-96		20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 NORTH FULTON AVENUE, BALTIMORE, MD. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Hepatic Failure</u> Due to (or as a consequence of): b. <u>Metastatic Endometrial Cancer</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number 024356		29d. Date signed (Month, Day, Year) MAY 1, 1996			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm C. WATERFIELD St Agnes Hospital 900 Caton Ave Balt, Md. 21229									
	31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13455

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>L. C. Gilles</i>						2. Date of Death Month <i>MAY</i> Day <i>07</i> Year <i>1996</i>		3. Time of Death <i>1940</i>		
	4a. Facility Name (If not institution, give street and number) CHURCH HOSPITAL						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 400-30-3657		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06-27-1927		9. Birthplace (State or Foreign Country) KENTUCKY		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 908 SHAMROCK COURT				10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1945- If Yes, Give Year or Dates: 1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY MANAGEMENT OFFICER			16b. Kind of Business/Industry N.S.A.				
17. Father's Name (First, Middle, Last) JOHN ELZIE GILLESS						18. Mother's Name (First, Middle, Maiden Surname) ELLA MAE YOUNG					
19a. Informant's Name/Relationship (Type, Print) JUANITA GILLESS						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 SHAMROCK CT., GLEN BURNIE, MD. 21060					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD. VETERAN CEMETERY		Date 5/10/96		20c. Location - City or Town, State CROWNSVILLE, MD.			
21. Signature of Funeral Service Licensee <i>Michael C. Gaffan</i>						22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or effect line. <i>Lung Cancer</i> Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death <i>2 weeks</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Pneumonia</i> <i>Diabetes Mellitus</i>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>W. Navarro</i>				29c. License number D40356		29d. Date signed (Month, Day, Year) MAY 07, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WENEUSA NAVARRO, MD. 100 N. BROADWAY, BALTIMORE, MARYLAND 21231											
31. Date filed (Month, Day, Year) MAY 08 1996											
32. Registrar's Signature <i>John H. Anderson</i>											

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13456

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jordan JOURDAN GIGGERS</i>				2. Date of Death Month <i>May</i> Day <i>6</i> Year <i>1996</i>		3. Time of Death <i>0305</i>	
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N.A.</i>	
Funeral Director	5. Social Security Number <i>220 39 4985</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>2</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>10/27/93</i>		9. Birthplace (State or Foreign Country) <i>MD</i>
	Usual Residence of Decedent							
10a. State <i>MD.</i>		10b. County <i>N.A.</i>		10c. City, Town or Location <i>BALTO.</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>4605 KAYON AVE</i>				10f. Zip Code <i>21206</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>BABY</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>NONE</i>		16b. Kind of Business/Industry <i>NONE</i>		
17. Father's Name (First, Middle, Last) <i>Willie Suggins</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Sherrie Cornish</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Sherrie Suggins</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4605 Kayon Ave Balto. Md 21206</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley mem. Pk 5/9/96</i>		Date		20c. Location - City or Town, State <i>Balto. County Md</i>		
21. Signature of Funeral Service Licensee <i>Joseph L. Locke Jr</i>				22. Name and Address of Facility <i>Locke Funeral Home 1304 N. Central Ave</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <i>Chronic Lung Disease</i>								<i>1 year</i>
Due to (or as a consequence of):								
b. <i>Alveolar Proteinosis</i>								<i>1 year</i>
Due to (or as a consequence of):								
c.								
Due to (or as a consequence of):								
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Keith Kow, MD</i>						
		29c. License number <i>045825</i>		29d. Date signed (Month, Day, Year) <i>May 6, 1996</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Keith Kow, MD 600 North Wolfe Street Baltimore, Maryland</i>								
31. Date filed (Month, Day, Year) <i>MAY 08 1996</i>		32. Registrar's Signature <i>John R. Smith</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13457

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH CARRETT HINDMAN</b>				2. Date of Death Month Day Year <b>MAY 7 1996</b>		3. Time of Death <b>10:39 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>217-58-9863</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 3 1907</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore City</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>835 E. Belvedere Avenue</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own home</b>	
17. Father's Name (First, Middle, Last) <b>Louis Siegrist</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Wolfe</b>				
19a. Informant's Name/Relationship (Type, Print) <b>W. Melvin Hindman Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>835 E. Belvedere Ave, Baltimore, MD 21212</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>May 10, 1996</b>		20c. Location - City or Town, State <b>Baltimore County</b>		
21. Signature of Funeral Service Licensee <b>Dean P Charlton</b>				22. Name and Address of Facility <b>Charlton Funeral Home 2007 Eastern Ave, Baltimore, MD 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. <b>Myocardial Infarction</b>								<b>10 min</b>
Due to (or as a consequence of): b. <b>Ischemic Cardiomyopathy</b>								<b>10 yr</b>
Due to (or as a consequence of): c. <b>Sick Sinus Syndrome</b>								<b>10 yr</b>
Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Barbara Kirchen MD</b>		29c. License number <b>D37134</b>		29d. Date signed (Month, Day, Year) <b>May 7, 1996</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Barbara Kirchen MD Good Samaritan Hospital</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <b>Julia Davidson-Rendell</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

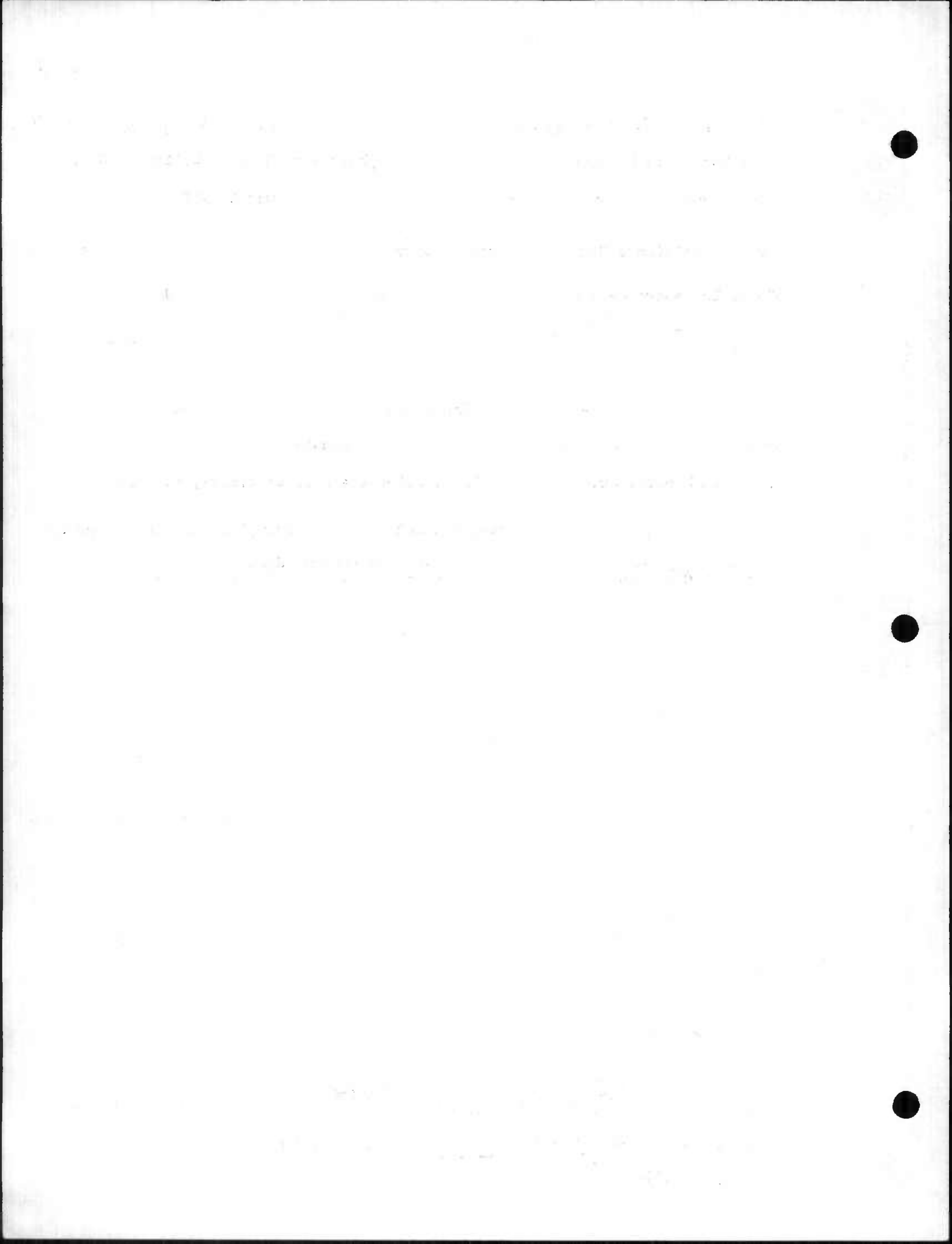
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar






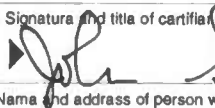
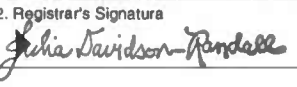
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13458

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES CURTIS HOLMES</b>				2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>11:10 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTH ARUNDEL NURSING &amp; REHABILITATION CENTER</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>218-09-4508</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01-17-1920</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2808 OAK GROVE AVENUE</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRINTER</b>		16b. Kind of Business/Industry <b>Printing</b> <del>PAINT</del> COMPANY		
17. Father's Name (First, Middle, Last) <b>CLARENCE WILMER HOLMES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE MARIE KRAFT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>EDITH F. HOLMES</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2808 OAK GROVE AVENUE, BALTIMORE, MD. 21227</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATORY, INC.</b>		Data		20c. Location - City or Town, State <b>BELTSVILLE, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. RESPIRATORY FAILURE</b> Due to (or as a consequence of):								<b>24 Hrs</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):								<b>15 Yrs</b>
<b>c. CHRONIC BRONCH PULMONARY</b> Due to (or as a consequence of):								<b>4 MONTHS</b>
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>027838</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN SHAVERS, 518 CAMP MEADE ROAD, LINTHICUM, MARYLAND 21090</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



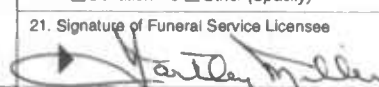


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13459

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NAOMI A. HOLTHAUS				2. Date of Death Month Day Year MAY 07, 1996		3. Time of Death 8:00 A.M.		
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TOWSON MD.		4c. County of Death BALTIMORE MD.		
Funeral Director	5. Social Security Number 213-46-2473		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) NOV 07, 1914		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE MARYLAND		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4301 HAMILTON AVE		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) N/A	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER		16b. Kind of Business/Industry HOME		17. Father's Name (First, Middle, Last) HENRY RENSHAW		18. Mother's Name (First, Middle, Maiden Surname) LILLY AKEHURST		19a. Informant's Name/Relationship (Type, Print) ROBERT M. HOLTHAUS	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4540 FITCH AVE BALTIMORE MARYLAND 21236		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM.		20c. Date 5/10		20d. Location - City or Town, State BALTIMORE MARYLAND	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MARYLAND 21234		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. LUNG CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Two years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D23043		29d. Date signed (Month, Day, Year) 5/7/96	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204		31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature 		33. Registrar's Name JULIA DAVIDSON-RENDALL		34. Registrar's Title REGISTRAR	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96-2251-043

CIP

ITEMS: 23 PART I, 27, PER MEO  
FILM G-735 5/10/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13460

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL

HUSSEY

2. Date of Death

APRIL 25, 1996

3. Time of Death

2:33PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

217-94-7636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04 15 64

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

509 HalfMile Court

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Various

17. Father's Name (First, Middle, Last)

Walter Hussey

18. Mother's Name (First, Middle, Maiden Surname)

Juanita

19a. Informant's Name/Relationship (Type, Print)

Juanita Hussey Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 HalfMile Court Balto. Md. 21201

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion

Date

May 1, 1996 Lansdown, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

UNITY FUNERAL HOME  
108 W. NORTH AVENUE BALTO. MD. 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CORONARY ARTERY THROMBOSIS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 26, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13461

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCIS ROSSLYN HOEFLICH				2. Date of Death Month 7, Day 1996 Year		3. Time of Death 12:15 A.M.			
	4a. Facility Name (If not institution, give street and number) Manor Care Towson				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 215-05-8545	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 4, 1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Parkville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 2724 Maple Avenue			10f. Zip Code 21234			10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator of Contracts			16b. Kind of Business/Industry Aero Space			
17. Father's Name (First, Middle, Last) Adolph F. Hoeflich				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Connolly						
19a. Informant's Name/Relationship (Type, Print) Sr. Patricia A. Hoeflich, S.N.D.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2724 Maple Ave. Baltimore, Maryland 21234						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 5/10/96		20c. Location - City or Town, State Parkville, Maryland			
21. Signature of Funeral Service Licensee <i>Paul L. Lange</i>				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Non Hodgkins Lymphoma  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Joseph Adams MD</i>			29c. License number D32783		29d. Date signed (Month, Day, Year) 5/7/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Adams, M.D. 7401 Osler Drive Suite 206 Towson, Md.										
31. Date filed (Month, Day, Year) MAY 08 1996			32. Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be clearly documented, including the date, amount, and purpose of the transaction. This ensures transparency and allows for easy auditing of the accounts.

2. The second part of the document outlines the procedures for reconciling the accounts. It states that the accounts should be reconciled at the end of each month. This involves comparing the balance sheet with the general ledger and identifying any discrepancies. If a discrepancy is found, it should be investigated immediately to determine the cause and corrected.

3. The third part of the document discusses the importance of maintaining proper documentation for all transactions. It states that all receipts, invoices, and other supporting documents should be kept in a secure and organized manner. This documentation is essential for proving the accuracy of the accounts and for resolving any disputes that may arise.

4. The fourth part of the document discusses the importance of maintaining accurate records of all assets and liabilities. It states that all assets should be properly valued and recorded, and all liabilities should be properly identified and recorded. This ensures that the balance sheet accurately reflects the financial position of the organization.

5. The fifth part of the document discusses the importance of maintaining accurate records of all income and expenses. It states that all income should be properly recorded and all expenses should be properly documented. This ensures that the income statement accurately reflects the financial performance of the organization.

6. The sixth part of the document discusses the importance of maintaining accurate records of all cash flows. It states that all cash inflows and outflows should be properly recorded and documented. This ensures that the cash flow statement accurately reflects the liquidity of the organization.

7. The seventh part of the document discusses the importance of maintaining accurate records of all fixed assets. It states that all fixed assets should be properly valued and recorded, and their depreciation should be properly calculated and recorded. This ensures that the balance sheet accurately reflects the value of the organization's fixed assets.

8. The eighth part of the document discusses the importance of maintaining accurate records of all intangible assets. It states that all intangible assets should be properly identified and recorded, and their value should be properly estimated. This ensures that the balance sheet accurately reflects the value of the organization's intangible assets.

9. The ninth part of the document discusses the importance of maintaining accurate records of all contingent liabilities. It states that all contingent liabilities should be properly identified and recorded, and their potential impact on the organization's financial position should be properly estimated. This ensures that the balance sheet accurately reflects the organization's financial position.

10. The tenth part of the document discusses the importance of maintaining accurate records of all other financial information. It states that all other financial information should be properly recorded and documented, including any changes in accounting policies or estimates. This ensures that the financial statements accurately reflect the financial position and performance of the organization.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NAM H. Hidalgo</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 04 1996</b>		3. TIME OF DEATH <b>19:52 M</b>	
4. SOCIAL SECURITY NUMBER <b>591-22-3349</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/18/1960</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Rep. of Korea</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Kimbrough Army Community Hosp</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FT G.G MEADE MD</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>	
10c. CITY, TOWN OR LOCATION <b>FORT MEADE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7735B NELSON COURT</b>	
10f. ZIP CODE <b>20755</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>KOREAN</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>07</b> College (1-4 or 5+) <b></b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSE WIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>PARK, Nak Chol</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CHONG, SO NYO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Hidalgo/Husband</b>				19b. MAILING ADDRESS <b>7735 B. Nelson Ct. Ft. Meade, MD 20755</b> <b>Republic of Korea, Seoul, Con Chon Ho, Si Hwang P Dong Th 7</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Calverton Nat'l Cem 5/7 Calverton, N.Y.</b>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert S. Desai</b>			
22. NAME AND ADDRESS OF FACILITY <b>Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD. 21228</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Lung Cancer</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Smoking</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate interval Between Onset and Death <b>30 hrs</b> <b>5 mths</b> <b>20 yrs</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Swati Desai, M.D.</b>				29c. LICENSE NUMBER <b>D-43417</b>		29d. DATE SIGNED (Month, Day, Year) <b>4 May 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Swati Desai, M.D. Kimbrough Army Comm. Hosp., Fort Meade, Md 20755</b>				31. DATE FILED (Month, Day, Year)			
32. REGISTRAR'S SIGNATURE							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



96 13463

Items: 3, 24a, 29c, 30 per M.D. G-735 5/8/96 reb

FOR STATE REGISTRAR Item: 1, per f.H. G-735 5/8/96

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**CERTIFICATE OF DEATH**

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Marta Hilliard</u> Hilliard				2. DATE OF DEATH MONTH <u>5</u> DAY <u>3</u> YEAR <u>96</u>		3. TIME OF DEATH <u>4:15</u> A. M.	
4. SOCIAL SECURITY NUMBER <u>177-34-5532</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>54</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/5/41</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>6029 Majors Lane, Apt. 1</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Columbia</u>		9c. COUNTY OF DEATH <u>Howard</u>	
10a. STATE <u>MD</u>				10b. COUNTY <u>Howard</u>		10c. CITY, TOWN OR LOCATION <u>Columbia</u>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>6029 Majors Lane, Apt. 1</u>			
10f. ZIP CODE <u>21045</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Secretary</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Drown &amp; Crown Financial Services</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Albert F. Hilliard</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Joyce Long</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Joyce Hilliard (Mother)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6029 Majors Lane, Columbia, MD 21045</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		20c. LOCATION — City or Town, State <u>May 7, 1996</u> <u>Catonsville, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>R. C. Witzke</u>				22. NAME AND ADDRESS OF FACILITY <u>Witzke Funeral Homes, Inc.</u> <u>5555 Twin Knolls Rd. Columbia, MD 21045</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardio pulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ASCVD</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Raynaud Syndrome</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death  <u>15 yrs</u> <u>25 yrs</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Theodore Watkins MD</u>				29c. LICENSE NUMBER <u>D-22696</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/4/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Theodore Watkins MD</u> <u>8115 FENTON ST. SILVER SPRING, MD. 20910</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 08 1996</u>				32. REGISTRAR'S SIGNATURE <u>R. C. Witzke</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13464

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM H. HOOD, JR.</b>				2. Date of Death Month <b>MAY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>1155Hrs</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>403-12-0612</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 4, 1917</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>N/A</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4120 Villa Nova Road</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanical Engineer</b>				16b. Kind of Business/Industry <b>State of Maryland</b>	
	17. Father's Name (First, Middle, Last) <b>William H. Hood, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Matilda Caldwell</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Stephen Hood Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1070 West Main Street Apt. 1012 Hendersonville, TN 37075</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation, Inc.</b>		20c. Location - City or Town, State <b>5/4/96 Hampstead, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Jane B. Covey</i>				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>DIABETIC KETOACIDOSIS</b> Due to (or as a consequence of): b. <b>METASTATIC PANCREATIC CARCINOMA</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 DAY</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>C. Ravi MD</i>		29c. License number <b>D37333</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, 1996</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>C. RAVI MD, MHC, BALTO. MD 21133</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13465

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONTAY C. HAMILTON		2. Date of Death Month Day Year APRIL 29 1996		3. Time of Death 1:53 A
	4a. Facility Name (If not institution, give street and number) 700 BLK PENNSYLVANIA AVE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number UNKNOWN	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) MAR. 14, 1975		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MARYLAND		
	10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 524 ORCHARD STREET		10f. Zip Code 21201		10g. Citizen of What Country? USA.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) TONY HAMILTON		18. Mother's Name (First, Middle, Maiden Surname) VALERIE BATES		
	19a. Informant's Name/Relationship (Type, Print) VALERIE BATES		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 ORCHARD STREET, BALTIMORE, MD. 212		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY 5-4-96 BALTIMORE, MARYLAND		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE. BALTIMORE, MD. 21217		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gun Shot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 4-29-96		28b. Time of Injury 0150 M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot			
28e. Place of Injury - At home, farm, sireal, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 700 BLK Pennsylvania Ave			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 29, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general  
description of the project. It includes the  
purpose, objectives, and scope of the study.  
2. The second part is a literature review.  
It discusses the work of other researchers  
in the field and identifies the gaps in  
knowledge that the current study aims to  
address.

3. The third part is the methodology.  
It describes the research design, data  
collection methods, and statistical analysis  
used in the study.  
4. The fourth part is the results.  
It presents the findings of the study and  
discusses their implications for practice  
and theory.

5. The fifth part is the conclusion.  
It summarizes the main findings of the  
study and provides recommendations for  
future research.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13466

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRMA J HOFFMAN					2. Date of Death Month Day Year MAY 3, 1996		3. Time of Death 18:47 P										
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A										
Funeral Director	5. Social Security Number 216-18-4297		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 25, 1921		9. Birthplace (State or Foreign Country) Maryland									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 717 Maiden Choice Lane				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home											
	17. Father's Name (First, Middle, Last) John M. Jacob					18. Mother's Name (First, Middle, Maiden Surname) Frances Tomachek												
	19a. Informant's Name/Relationship (Type, Print) John H. Hoffman (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Maiden Choice Lane Catonsville, Maryland													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date May 7, 1996		20c. Location - City or Town, State Baltimore, Maryland										
	21. Signature of Funeral Service Licensee R. Gay Witzke Jr.				22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228													
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Ventricular Fibrillation</td> <td rowspan="4">           Approximate Interval Between Onset and Death             approx 40mins             approx 10 yrs. ago         </td> </tr> <tr> <td>b.</td> <td>Myocardial infarction</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	Approximate Interval Between Onset and Death  approx 40mins  approx 10 yrs. ago	b.	Myocardial infarction	c.		d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	Approximate Interval Between Onset and Death  approx 40mins  approx 10 yrs. ago															
	b.	Myocardial infarction																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred									
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier Isadore Feldman, MD					29c. License number D20676		29d. Date signed (Month, Day, Year) May 3, 1996											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isadore Feldman St. Agnes Hosp 900 Caton Ave. Balto, Md 21229																		
31. Date filed (Month, Day, Year) MAY 8 1996																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13467

## Certificate of Death

Reg. No.

ITEM#1 film 8735 5/13/96ag perAG

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIET G. HEROLD

2. Date of Death

Month  
MAYDay  
5Year  
1996

3. Time of Death

530P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

216-56-5071

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 4, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4726 Roundhill Road

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Para Legal

16b. Kind of Business/Industry

Rouse Company

17. Father's Name (First, Middle, Last)

Vincent J. Lawler Jr.

18. Mother's Name (First, Middle, Maiden Summa)

Barbara Broening

19a. Informant's Name/Relationship (Type, Print)

Henry Herold (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4726 Roundhill Road Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Veterans Cemetery

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes Of Catonsville, Inc.  
1630 Edmondson Avenue Catonsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 H

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31473

29d. Date signed (Month, Day, Year)

May 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICE A. TOLE, MD 4565 Hemlock Lane Way Ellicott City MD 21042

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13468

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DWAYNE JOHNSON</b>		2. Date of Death Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>1:37 A</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-92-0894</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>20</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>08 15 75</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>211 Bethel Court</b>		10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Job Corp</b>		16b. Kind of Business/Industry <b>Unknown</b>		
	17. Father's Name (First, Middle, Last) <b>Raymond Johnson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sylister Commodore</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sylister Commodore/ mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>211 Bethel Court Balto. Md. 21201</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOUNT ZION CEMETERY</b>		20c. Location - City or Town, State <b>4/2/96 Lansdowne, Md.</b>
	21. Signature of Funeral Service Licensee <i>Joseph R. Watters</i>		22. Name and Address of Facility <b>UNITY FUNERAL HOME</b> <b>103 W. North Avenue Balto. Md. 21201</b>		
23a. Part I. Enter the disease, or complications that caused the death, or not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. GUNSHOT WOUNDS OF CHEST AND LEFT ARM</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>4 26 96</b>		28b. Time of Injury <b>2354 PM</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <b>SHOOTING</b>			
28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>200 N. CENTRAL AVE BALTIMORE MD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.  29b. Signature and title of certifier <i>Magister Daniel Kelle</i> 29c. License number <b>O.C.M.E</b> 29d. Date signed (Month, Day, Year) <b>APRIL 27, 1996</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARYANN A. KOROWA 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <i>Julia Davidson-Pendell</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 13469

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edith JAMES</b>					2. Date of Death Month <b>5</b> Day <b>8</b> Year <b>96</b>		3. Time of Death <b>9:15 A.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>1524 HOLBROOK ST</b>					4b. City, Town, or Location of Death <b>BALTO</b>		4c. County of Death <b>N.A.</b>			
Funeral Director	5. Social Security Number <b>216 12-299</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9-12-10</b>		9. Birthplace (State or Foreign Country) <b>Md</b>		
	Usual Residence of Decedent										
10a. State <b>Md.</b>		10b. County <b>N.A.</b>		10c. City, Town or Location <b>BALTO.</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>1524 HOLBROOK AVE</b>					10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>BABY UNKNOWN</b> College (1-4 or 5+)					18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NONE</b>			16b. Kind of Business/Industry <b>NONE</b>			
17. Father's Name (First, Middle, Last) <b>WM BARFIELD JAMES</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARY ELIZABETH HOLLEN</b>						
19a. Informant's Name/Relationship (Type, Print) <b>MARY ANN BATTLE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1524 HOLBROOK ST BALTO, MD 21202</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. ZION CEM</b>		20c. Location - City or Town, State <b>5/11/96 LANDSDOWNE MD</b>						
21. Signature of Funeral Service Licensee <b>Joseph B. Locks Jr</b>					22. Name and Address of Facility <b>Locks Funeral Home 1304 N. Central Ave</b>						
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Upper GI Bleeding</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Dr. Martin</b>					29c. License number <b>D 42561</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Martin P. Patten, M.D. 341 N. Calvert St #302 Baltimore, MD 21202</b>											
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>					32. Registrar's Signature <b>Don Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13470

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALLEN JAMES</b>				2. Date of Death Month <b>MAY</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>1:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hosp.</b>				4b. City, Town, or Location of Death <b>Balto.</b>		4c. County of Death <b>N. A</b>	
Funeral Director	5. Social Security Number <b>216-10-0957</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6/25/04</b>	
	9. Birthplace (State or Foreign Country) <b>md</b>		10a. State <b>md</b>		10b. County <b>N. A</b>		10c. City, Town or Location <b>Balto.</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Harford Garden Nursing Home</b>		10f. Zip Code		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTER</b>		16b. Kind of Business/Industry <b>CONTRACTOR</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>	
	17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Hazel James (sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1349 Winton Ave Balto. Md 21239</b>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT ZION Cem.</b>		20c. Location - City or Town, State <b>5/11/96 Randallstown Md</b>		21. Signature of Funeral Service Licensee <b>Joseph B. Locks Jr</b>	
	21. Signature of Funeral Service Licensee <b>Joseph B. Locks Jr</b>		22. Name and Address of Facility <b>Locks Funeral Home 1304 N. Central Ave</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASYSTOLE</b> Due to (or as a consequence of): <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of): <b>UROSEPSIS</b>		Approximate Interval Between Onset and Death <b>MINUTES</b> <b>DAYS</b> <b>WEEKS</b> <b>WEEKS</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA YEARS</b> <b>CLOSTRIDIUM DIFFICILE COLITIS - DAYS</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Medical Doctor</b>	
To Be Completed by Physician/Medical Examiner	29c. License number <b>PO 9306</b>		29d. Date signed (Month, Day, Year) <b>MAY 30 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FRANCIS KWASHIE ATOGBE THE GOOD SAMARITAN HOSP OF MARYLAND IN.</b>		31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>	
	32. Registrar's Signature <b>Don Handell</b>		33. State Registrar		34. State Registrar		35. State Registrar	



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13471

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALFRED JOHNSON SR.</b>				2. Date of Death Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>4:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1814 WALBROOK AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-18-9592</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 31, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1814 WALBROOK AVENUE</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3RD GRADE</b>		College (14 or 5+) <b>COLLEGE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REAL ESTATE</b>		16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>	
	17. Father's Name (First, Middle, Last) <b>JESSIE TURNER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MATTIE (MN-UNKNOWN)</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>BERNICE JOHNSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1814 WALBROOK AVENUE BALTIMORE, MD. 21217</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. Location - City or Town, State <b>5-1-96 WOODLAWN, MARYLAND</b>		20d. Location - City or Town, State <b>WOODLAWN, MARYLAND</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Cerebral vascular disease</b> Due to (or as a consequence of): b. <b>Diabetes</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>DO 7259</b>		29d. Date signed (Month, Day, Year) <b>5-1-96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John J. Mann, M.D. 10555 Falls Rd. Ste 200 Lutherville, MD 21093</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 			
	<b>5</b>							

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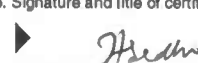
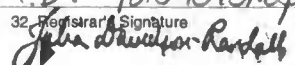
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 13472

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH JENKINS</b>				2. Date of Death Month Day Year <b>APRIL 30, 1996</b>		3. Time of Death <b>0125 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Alleghany</b>	
Funeral Director	5. Social Security Number <b>215-16-4989</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>7-1-20</b>	9. Birthplace (State or Foreign Country) <b>Mt. Savage, MD</b>
	Usual Residence of Decedent							
10a. State <b>WV</b>		10b. County <b>Alleghany</b>		10c. City, Town or Location <b>Cumberland</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <b>12006 Mulberry Ave. S.W.</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>			16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>Joseph Jenkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eliza Brown Jenkins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary T. Nies Jenkins</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12006 Mulberry Ave., Patomac Park MD 21502</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WVU-Human Gift Registry</b>		Date <b>4/30/96</b>		20c. Location - City or Town, State <b>Morgantown, WV</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WVU-HGR, Morgantown, WV 26506</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARCINOMA OF PANCREAS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIABETES MELLITUS</b>								Approximate Interval Between Onset and Death <b>10 MONTHS</b>
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D 26907</b>		29d. Date signed (Month, Day, Year) <b>APRIL 30, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hargit Sidhu, M.D. 925 Bishop Walsh Road Cumberland, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 502-687-6000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that this certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13473

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY LUTHER JOHNSON

2. Date of Death

Month Day Year

MAY 1 1996

3. Time of Death

6:45pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

STELLA MARIS of Mercy

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

NA

5. Social Security Number

218-67-4052

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4 11 55

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

615 E. 33rd

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registra

16b. Kind of Business/Industry

Sina Hospital

17. Father's Name (First, Middle, Last)

Donald Smith

18. Mother's Name (First, Middle, Maiden Surname)

Dorothea Johnson

19a. Informant's Name/Relationship (Type, Print)

Dorothea Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 E 33rd Street BALTO. MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cemetery

Date

5/8/96

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller PC F/H 1639 N. Broadway BALTO. MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

b. HIV INFECTION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

UNKNOWN

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) stella maris at mercy

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Johnson

29c. License number

240480

29d. Date signed (Month, Day, Year)

May 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FERNANDO J. FERRO, MD

5810 BELAIR RD BALTO., MD 21206

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

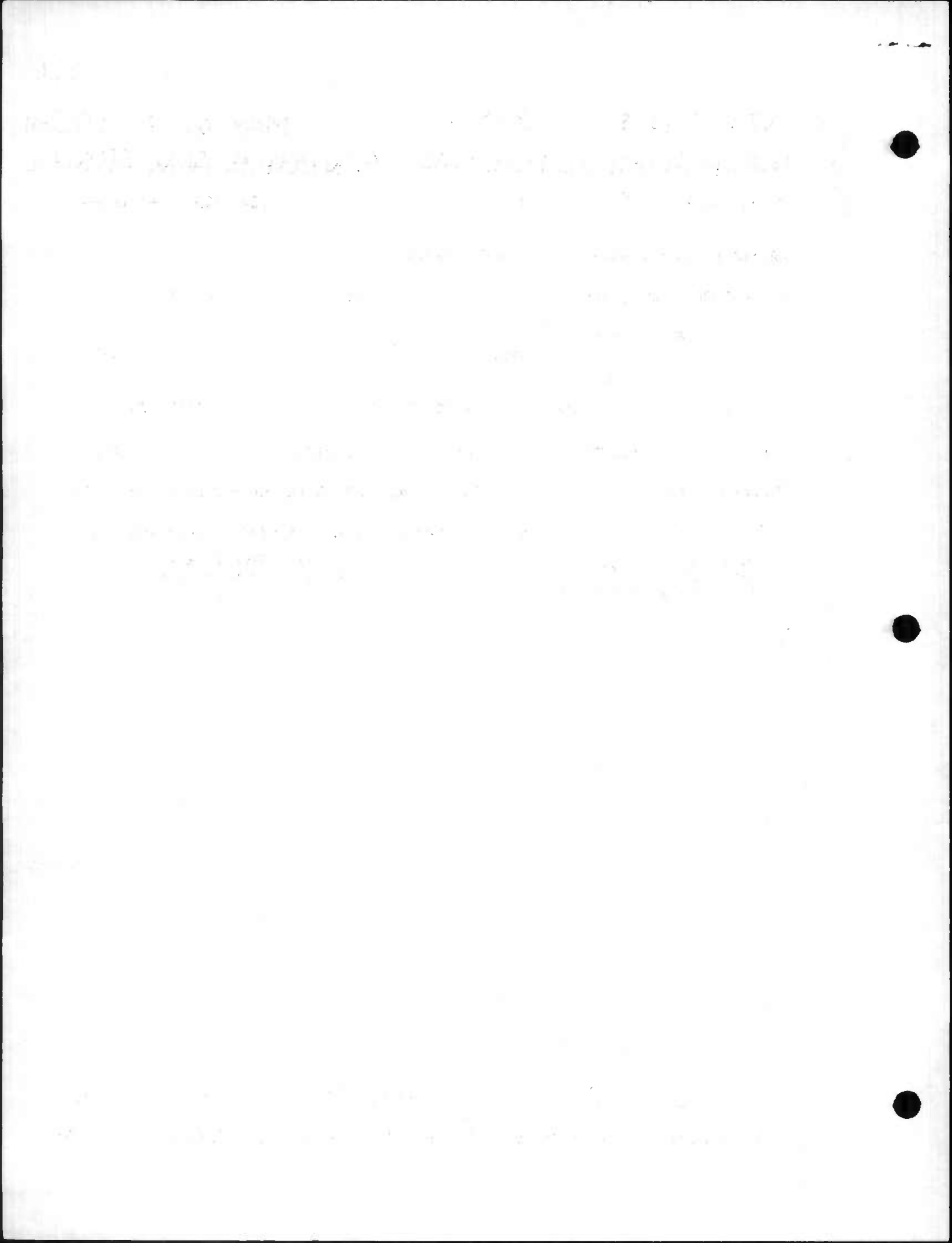
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13475

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHARON KELLY				2. Date of Death Month Day Year MAY 3 1996		3. Time of Death 1855	
	4a. Facility Name (If not institution, give street and number) St. Agnes				4b. City, Town, or Location of Death Balto		4c. County of Death NIA	
Funeral Director	5. Social Security Number 214-76-0021		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs, last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) July 8, 1963	
	9. Birthplace (State or Foreign Country) md		10a. State md		10b. County Balto		10c. City, Town or Location Balto	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6317 Johnny cake Rd		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary		16b. Kind of Business/Industry Visiting Nurses Ass.			
	17. Father's Name (First, Middle, Last) John Dalton				18. Mother's Name (First, Middle, Maiden Surname) Florence C. Forrest			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dorsey J. Kelly - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 Johnny cake Rd Balto, md 21207			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Garrison Forest vet		20c. Location - City or Town, State 5/9/96 Owings Mills, md			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Gabrielle Cook				22. Name and Address of Facility Mann F.H. - West 4300 Waxbush Ave			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. respiratory failure Due to (or as a consequence of): b. HIV infection Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 5 min. 1 year
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Kongsak Chantornsang, M.D.				29c. License number PO-9145		29d. Date signed (Month, Day, Year) MAY 3, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONGSAK CHANTORNSAENG 900 CATON AVE. BALTIMORE, MD							
State Registrar	31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13476

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ISAAH LEOPOLD

2. Date of Death

Month MAY 3 Day 1996 Year

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

320 TUNBRIDGE RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-20-3618

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

12-12-1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

320 TUNBRIDGE RD.

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: *WWII*

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MARKETING DIRECTOR

18b. Kind of Business/Industry

ADVERTISING

17. Father's Name (First, Middle, Last)

HARRY B. LEOPOLD

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE HOFFMAN

19a. Informant's Name/Relationship (Type, Print)

HELEN LEOPOLD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 TUNBRIDGE RD. BALTO., MD. 21212.

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

5/7/96

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

*William R. Davis III*

22. Name and Address of Facility

HENRY W. JENKINS &amp; SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *arteriosclerotic vascular / heart disease*

Due to (or as a consequence of):

b. *Hypertension*

Due to (or as a consequence of):

c. *hypercholesterolemia*

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dana Frank*

29c. License number

D26003

29d. Date signed (Month, Day, Year)

5/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANA FRANK M.D. 10756 FALLS RD. SUITE 200 BALTO., MD

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

*John Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13477

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Joseph Lyons, Sr.				2. Date of Death Month Day Year May 3, 1996		3. Time of Death 3:30 A.M.	
	4a. Facility Name (If not institution, give street and number) 725 Hunter Way				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-16-5986	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/22/1923		9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel		10c. City, Town or Location Linthicum			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 520 Dogwood Rd.			10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) District MGR. ADT			16b. Kind of Business/Industry Security	
	17. Father's Name (First, Middle, Last) Leonard A. Lyons				18. Mother's Name (First, Middle, Maiden Summa) Gertrude Magee			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathy Mettee/ Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Hunter Way Catonsville, MD. 21228				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		Data 5/6/96		20c. Location - City or Town, State Glen Burnie, MD.	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD. 21228				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic bladder cancer</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <u>20 months</u>							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D18587		29d. Date signed (Month, Day, Year) MAY 3 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul GORMLEY 900 CATON AVE BALTO. MD 21229								
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12+1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13478

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Warren Lewis</b>				2. Date of Death Month <b>5</b> Day <b>7</b> Year <b>96</b>		3. Time of Death <b>01:27 am</b>	
4a. Facility Name (If not institution, give street and number) <b>University Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>213-64-5204</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-6-54</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1013 CROSS STREET</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Water Works (Laborer)</b>		16b. Kind of Business/Industry <b>Baltimore City</b>	
17. Father's Name (First, Middle, Last) <b>William Lewis Jr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Ewell Lewis</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Steven M. Lewis - Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Nairam Ct. Baltimore, MD. 21133</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Date <b>5-10-96</b>		20d. Location - City or Town, State <b>Landowne, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie FH PA</b> <b>638 N. Gilmer Street</b> <b>21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiovascular collapse</b> Due to (or as a consequence of): b. <b>Infection</b> Due to (or as a consequence of): c. <b>AIDS</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>S Kupferschmid, M.D.</b>				29c. License number <b>P09746</b>		29d. Date signed (Month, Day, Year) <b>5/7/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Seth Kupferschmid, M.D.</b>							
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature <b>Lelia Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13479

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marriam MORSLEY</b>				2. Date of Death Month <b>May</b> Day <b>3rd</b> Year <b>1996</b>		3. Time of Death <b>9:20am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital 2000 W. Balto.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-36-0583</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02/12/39</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>2032 E. 30th Street</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		College (1-4 or 5+) <b>-0-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teachers Asst.</b>		16b. Kind of Business/Industry <b>Education</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Rufus Webb</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Rowlette</b>			
	19a. Informant's Name/Relationship <b>Sharyl Smith (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3213 Sequoia Ave, Balto, MD 21215</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cem.</b>		Date <b>5/8/96</b>	20c. Location - City or Town, State <b>Pikeville</b>		
	21. Signature of Funeral Service Licensee <i>Shuretha Roberts CFSP #281</i>				22. Name and Address of Facility <b>E.L. Phillips Funeral Home 1721-27 N. Monroe St. Balto, MD 21217</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Pancreatic Cancer</b> Due to (or as a consequence of): b. <b>Overwhelming Sepsis</b> Due to (or as a consequence of): c. <b>Left Buttock Decubitus</b> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>6 months</b> <b>1 month</b> <b>1 month</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Sharon Elder MD Attending</i>				29c. License number <b>D38993</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Sharon Elder MD 2600 Liberty Hgts Baltimore MD 21215</i>							
	31. Date filed (Month, Day, Year)				32. Registrar's Signature <b>3</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the smooth operation of any business and for the protection of its interests.

2. The second part of the document outlines the various methods used to collect and analyze data. It describes the process of gathering information from different sources and how this data is then used to make informed decisions.

3. The third part of the document focuses on the role of technology in modern business operations. It highlights the benefits of using digital tools for communication, data storage, and analysis, and discusses the challenges associated with implementing these technologies.

4. The fourth part of the document addresses the issue of financial management. It provides a detailed overview of the various financial statements and how they are used to assess the financial health of a company.

5. The fifth part of the document discusses the importance of human resources in a business. It explores the different ways in which a company can attract, develop, and retain its workforce, and the impact of these efforts on the overall success of the organization.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13480

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROOSEVELT MCKENZIE</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>10:04 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOUR Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-46-0015</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	8. Date of Birth Month <b>Nov.</b> Day <b>4</b> Year <b>1929</b>	9. Birthplace (State or Foreign Country) <b>S. Carolina</b>		
	Usual Residence of Decedent				10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits	
	10e. Street and Number <b>2048 BRADDOCK AVENUE</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>High grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>		16b. Kind of Business/Industry <b>Private Business</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOHN L. MCKENZIE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAUDE HEMMING</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Annie Mason Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2048 BRADDOCK AVE Baltimore, Md 21216</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Center</b>		20c. Location - City or Town, State <b>Baltimore Md</b>		20d. Date <b>5-6-96</b>	
	21. Signature of Funeral Service Licensee <b>Quay Harris</b>				22. Name and Address of Facility <b>CHARTMAN - Harris Funeral Home 5540 Reisterstown Road Baltimore, Md 21215</b>			
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b>						Approximate Interval Between Onset and Death	
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>BILATERAL PNEUMONIA</b> <b>METABOLIC ACIDOSIS</b> <b>RENAL FAILURE</b>						Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>UTI</b> <b>GI bleeding</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Quay Harris</b>		29c. License number <b>D31905</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMBACHEN WORETA 2431 MARYLAND AVE BALTIMORE Md 21218</b>						31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13481

Filmg, 735, item #17, 5/24/96,cyw, per fh

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Donohue Murphy						2. Date of Death Month 4 Day 1996 Year		3. Time of Death 7:30 A.M.	
	4e. Facility Name (If not institution, give street and number) 71 Edmondson Ridge Rd.						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-01-5237		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 11/16/1912		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD.		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 71 Edmondson Ridge Rd.				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Collegia (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Social Security			16b. Kind of Business/Industry Government			
17. Father's Name (First, Middle, Last) THOMAS John Donohue						18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Mannion				
19a. Informant's Name/Relationship (Type, Print) Maureen Keck/ Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Oak Drive. Catonsville, MD. 21228				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem.		Date 5/7/96		20c. Location - City or Town, State Baltimore, MD.			
21. Signature of Funeral Service Licensee Peter S. [Signature]						22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD. 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Liver Failure Due to (or as a consequence of): b. Cirrhosis of the liver. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 6m
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Co Breast							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]			29c. License number D08780		29d. Date signed (Month, Day, Year) 5/6/96		
30. Name and address of person who completed cause of death (I am 23a) (Type, Print) 405 Frederick Rd. St. 100 Catonsville MD 21228										
31. Date filed (Month, Day, Year) MAY 08 1996					32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 13482

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA CORDELLA MATTHEWS

2. Date of Death

Month Day Year  
APRIL 29 1996

3. Time of Death

7:45 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7352 DOTSON LANE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

A. A. COUNTY

5. Social Security Number

214-14-3044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
JULY 3, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

A. A. COUNTY

10c. City, Town or Location

SEVEN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7352 DOTSON LANE

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12<sup>TH</sup> GRADE

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

DANIEL C. DOTSON

18. Mother's Name (First, Middle, Maiden Summa)

CORDELLA BROOKS

19a. Informant's Name/Relationship (Type, Print)

JANICE JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 LESLIE CT., SEVERN PK. MD. 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DOTSON FAMILY CEMETERY

Data

5-4-96

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

D. Brown

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P. A.  
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory arrest  
Due to (or as a consequence of):b. Myocardial infarction  
Due to (or as a consequence of):c. Hypertensive cardiovascular disease  
Due to (or as a consequence of):

d. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension, asthma by history  
thyroid gland etc.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark J. Matthews MD

29c. License number

008801

29d. Date signed (Month, Day, Year)

5-4-96

30. Name and address of person who completes cause of death (Item 23e) (Type, Print)

795 Aqueduct Rd, St 110, Glen Burnie Md. 21061

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

Julia Brown-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general  
description of the area. It is a small  
area, about 1000 acres, and is  
located in the north-east corner of the  
county.

2. The second part of the report is a  
description of the land. It is a  
small area, about 1000 acres, and is  
located in the north-east corner of the  
county.

3. The third part of the report is a  
description of the land. It is a  
small area, about 1000 acres, and is  
located in the north-east corner of the  
county.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13483

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Grace Manning</b>					2. Date of Death Month <b>05</b> Day <b>01</b> Year <b>96</b>		3. Time of Death <b>10:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>216-01-6116</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>JAN. 09, 1910</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2906 BAKER STREET</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LAB ASSISTANT</b>		16b. Kind of Business/Industry <b>BECTON &amp; DICKERSON Co.</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>CHARLES BROWN</b>				16. Mother's Name (First, Middle, Maiden Surname) <b>ELLA OTHO</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>CONRAD TURNER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7849 PADDOCK WAY, BALTIMORE, MD. 21244</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY 5-6-96</b>		Date		20c. Location - City or Town, State <b>ARBUTUS, MARYLAND</b>		
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Encysted pneumonia</b> <b>Uncontrolled Congenital Hernia</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D34730</b>		29d. Date signed (Month, Day, Year) <b>5/1/96</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2000 W Balti St.</b>								
	31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <b>Julia Jackson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13484

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SUZANNE MOTSKO</b>				2. Date of Death Month Day Year <b>MAY 03 1996</b>		3. Time of Death <b>12:46PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>217-14-6890</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 27, 1923</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>10085-2 Windstream Drive</b>			10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+) <b>5+</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Principal</b>		18b. Kind of Business/Industry <b>Baltimore County School System</b>	
	17. Father's Name (First, Middle, Last) <b>Seymour W. Ruff</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary West</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>William A. Motsko (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10085-2 Windstream Drive, Columbia, MD 21044</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro crematory</b>		May Data <b>6, 1996</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory failure</b> Due to (or as a consequence of): b. <b>Parkinson's disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Shy-Drager Syndrome</b>							Approximate Interval Between Onset and Death <b>49 hrs.</b> <b>Several years</b>
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Abed Al Khan M.D.</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ABEDA ALI KHAN TWO KNOLL NORTH DRIVE COLUMBIA MD 21045</b>		31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 		29c. License number <b>D43323</b>		29d. Date signed (Month, Day, Year) <b>MAY 03, 1996</b>

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13485

## Certificate of Death

Reg. No.

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Catherine

A

Nash

2. Date of Death

Month

Day

Year

May 7, 1996

3. Time of Death

7:12 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4116 Southern Ave.

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

N/A

5. Social Security Number

218-14-9723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

December 15, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore, City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4116 Southern Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Timmerman

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Brown

19a. Informant's Name/Relationship (Type, Print)

Mr. William K. Nash - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10e

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corporation

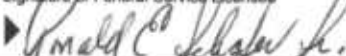
Date

5/8/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road - Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic Obstructive Pulmonary Disease

Approximate Interval Between Onset and Death

Decade

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D40609

29d. Date signed (Month, Day, Year)

5/7/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)


1005 No Point Blvd - Suite 700, Balto, MD 21224

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13486

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA ~~NADOLSKI~~ Mae P. Nadolski

2. Date of Death

Month Day Year  
MAY 7 1996

3. Time of Death

5:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

217-38-8732

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-24-1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

206 MARGATE DRIVE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN GILES

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

BETTY LOU HESEMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 MARGATE DRIVE GLEN BURNIE, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

MAY, 9

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, PA  
1 SECOND AVE., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTED HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MAY 7, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSHUA IMPERIO

301 HOSPITAL DRIVE, GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 13487

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month      Day      Year		3. Time of Death								
	ALBERT LUDWIG NUSSE						MAY 6, 1996		7:30 P.M.								
Funeral Director	4a. Facility Name (If not institution, give street and number)								4b. City, Town, or Location of Death		4c. County of Death						
	NURSING & REHABILITATION CENTER								GLEN BURNIE		ANNE ARUNDEL						
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs.		If Under 1 Year Months   Days		If Under 24 Hrs. Hours   Min.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)				
	089-01-6518				88						08-25-1907		GERMANY				
	Usual Residence of Decedent																
	10a. State				10b. County				10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No				
	MARYLAND				ANNE ARUNDEL				GLEN BURNIE								
	10e. Street and Number								10f. Zip Code		10g. Citizen of What Country?						
	508 STANHOME DRIVE								21061		U.S.A.						
	11. Marital Status 1 <input type="checkbox"/> Never Married    2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed    4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No    Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed)						16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry						
	Elementary/Secondary (0-12) 12      College (1-4 or 5+) N/A						COSMETOLOGIST				SALON						
17. Father's Name (First, Middle, Last)								18. Mother's Name (First, Middle, Maiden Surname)									
LANDOLIN NUSSE								KUNIGUNDE (UNKNOWN)									
19a. Informant's Name/Relationship (Type, Print)								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
WENDY F. GILBERT								7867 HICKORY LEAF ROAD, SEVERN, MARYLAND 21144									
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial    2 <input type="checkbox"/> Cremation    3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation    5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State							
				NATIONAL MEMORIAL PARK				5/10/96		FALLS CHURCH, VA.							
21. Signature of Funeral Service Licensee								22. Name and Address of Facility									
								SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061									
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														Approximate Interval Between Onset and Death			
<div style="float: left; width: 25%;">Immediate Cause (Final disease or condition resulting in death)</div> <div style="clear: both;"></div> <div style="margin-top: 20px;"> <p>e. Lung Cancer Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div>														}		1 1/2 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
Coronary artery disease Hypertension Chronic obstructive lung disease																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient    2 <input type="checkbox"/> ER/Outpatient    3 <input type="checkbox"/> DOA    Other: 4 <input checked="" type="checkbox"/> Nursing Home    5 <input type="checkbox"/> Residence    6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural    5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident    6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide    4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No		28d. Describe how injury occurred							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier								29c. License number				29d. Date signed (Month, Day, Year)					
								D 25000				May 6, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)																	
PO-Hickory Hill, MD 21066 Crain Highway, SW #8 Glen Burnie																	
31. Date filed (Month, Day, Year)																	
MAY 08 1996																	
32. Registrar's Signature																	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13488

Item 31, Film 735, 5/8/96, 1t Item 1

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oddvar KRISTIAN Nielsen						2. Date of Death Month Day Year May 04, 1996		3. Time of Death 10:00 AM										
	4a. Facility Name (If not institution, give street and number) 1131 D Charles View Way						4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.										
Funeral Director	5. Social Security Number N/A		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 09 1917		9. Birthplace (State or Foreign Country) Norway										
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 1131 D Charles View Way				10f. Zip Code 21204		10g. Citizen of What Country? Norway												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chancellor/Norway				16b. Kind of Business/Industry Finance												
	17. Father's Name (First, Middle, Last) Trigva Nielsen				18. Mother's Name (First, Middle, Maiden Surname) Gudrun Unknown														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Svein Nielsen/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Prides Crossing Shenandoah Junction, W.VA. 25442														
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 5-7-96		20c. Location - City or Town, State Towson, Md.												
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>CARDIOMYOPATHY</td> <td rowspan="4">           Approximate Interval Between Onset and Death            2 YEARS            20 plus YEARS         </td> </tr> <tr> <td>b.</td> <td>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIOMYOPATHY	Approximate Interval Between Onset and Death 2 YEARS 20 plus YEARS	b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	c.		d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIOMYOPATHY	Approximate Interval Between Onset and Death 2 YEARS 20 plus YEARS																
	b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 		29c. License number D 06933		29d. Date signed (Month, Day, Year) Saturday, May 04, 1996															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN B. MACGRAWSON																			
31. Date filed (Month, Day, Year) MAY 4 1996		32. Registrar's Signature Julia Davidson-Rendall																	

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13489

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clifton Nicholson</b>				2. Date of Death Month <b>05</b> Day <b>02</b> Year <b>96</b>		3. Time of Death <b>10:58 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greenspring Nursing &amp; Rehab Center</b>				4b. City, Town, or Location of Death <b>Baltimore, MD.</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>213-16-3791</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 14, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>4615 PARK HEIGHTS AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA.</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>LANDSCAPING COMPANY</b>			
	17. Father's Name (First, Middle, Last) <b>GEORGE CRENSHAW</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MABEL NICHOLSON</b>		19a. Informant's Name/Relationship (Type, Print) <b>CHARLES NICHOLSON</b>			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2511 EDMONDSON AVE., BALTIMORE, MD. 21223</b>		20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>5-3-96 BALTIMORE, MD.</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>JOSEPH A. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ACUTE CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): <b>b. CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of): <b>c. ESSENTIAL HYPERTENSION</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>Acute</b> <b>YEARS</b> <b>YEARS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier <b>[Signature]</b>
	29c. License number <b>D-19425</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4615 PARK HEIGHTS BALTIMORE, MD. 21215</b>							
	31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <b>[Signature]</b>					





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAULINE Nadarzynski <del>NADARZYUSKI</del>				2. Date of Death Month Day Year MAY 06, 1996		3. Time of Death 3:49 PM.			
	4a. Facility Name (If not institution, give street and number) 604 N. BOULDIN ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death			
Funeral Director	5. Social Security Number 220-14-6526		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/16/1919	9. Birthplace (State or Foreign Country) Baltimore		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 604 N. Bouldin Street				10f. Zip Code 21205		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Assembly		16b. Kind of Business/Industry Esskay					
	17. Father's Name (First, Middle, Last) William Cyerwinski				16. Mother's Name (First, Middle, Maiden Sumama) Augusta					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Daughter Patricia Zito				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91320 344 Corrine Hill Ct. Thousand Oaks Cal.					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		Data 5/8/96		20c. Location - City or Town, State Baltimore, Md.			
	21. Signature of Funeral Service Licensee Maria M. Zannino				22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Baltimore, Md. 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26d. Describe how Injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier J. Laron Locke M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 07, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201										
State Registrar	31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature John Davidson-Randall							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13491

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred K. Osborn</b>				2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>0901</b>								
	4a. Facility Name (If not institution, give street and number) <b>St. Joseph Hospital</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>								
Funeral Director	5. Social Security Number <b>215-32-8300</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 26, 1913</b>								
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>								
Usual Residence of Decedent															
10a. State <b>Md.</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Reisterstown</b>									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number <b>4715 Piney Grove Road</b>			10f. Zip Code <b>21136</b>									
10g. Citizen of What Country? <b>USA</b>			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:									
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>									
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			17. Father's Name (First, Middle, Last) <b>Charles E. Turnbaugh</b>									
18. Mother's Name (First, Middle, Maiden Surname) <b>Iva F. Young</b>			19a. Informant's Name/Relationship (Type, Print) <b>Charles E. Konze / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>825 S. Main St. Hampstead, Md. 21074</b>									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Gilead Cemetery</b>			20c. Location - City or Town, State <b>5-9-96 Reisterstown, Md.</b>									
21. Signature of Funeral Service Licensee <b>E. Brian Powell</b>			22. Name and Address of Facility <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">}</td> <td>a. <b>Dissecting aneurysm, proximal aorta</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>2 hours</b></td> </tr> <tr> <td>b. <b>Aortic atherosclerosis</b></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	}	a. <b>Dissecting aneurysm, proximal aorta</b>	Approximate Interval Between Onset and Death <b>2 hours</b>	b. <b>Aortic atherosclerosis</b>	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	}	a. <b>Dissecting aneurysm, proximal aorta</b>	Approximate Interval Between Onset and Death <b>2 hours</b>												
		b. <b>Aortic atherosclerosis</b>													
		c. Due to (or as a consequence of):													
		d. Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
<table border="0"> <tr> <td><b>Aortic insufficiency; S/P aortic valve</b></td> <td>23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td><b>Replacement (05/02/96); marked cardiac hypertrophy.</b></td> <td>24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td></td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>									<b>Aortic insufficiency; S/P aortic valve</b>	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	<b>Replacement (05/02/96); marked cardiac hypertrophy.</b>	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
<b>Aortic insufficiency; S/P aortic valve</b>	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
<b>Replacement (05/02/96); marked cardiac hypertrophy.</b>	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined															
28a. Date of Injury (Month, Day, Year)															
28b. Time of Injury <b>M</b>															
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
28d. Describe how Injury occurred															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)															
28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <b>DIRECTOR, DEPT OF PATHOLOGY</b>															
29c. License number <b>D14873</b>															
29d. Date signed (Month, Day, Year) <b>5/6/96</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James W. Eagan, Jr., M.D., St. Joseph Med.Center, 7620 York Rd., Towson, MD 21204</b>															
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>															
32. Registrar's Signature <b>Julia Anderson-Rodriguez</b>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

The first part of the paper is devoted to a discussion of the  
 various methods which have been proposed for the determination of  
 the rate of reaction between a solid and a liquid. It is shown that  
 the most reliable method is that of measuring the change in weight  
 of the solid as the reaction proceeds. This method is applicable to  
 all cases in which the solid is insoluble in the liquid. It is  
 also applicable to cases in which the solid is soluble in the liquid,  
 provided that the solid is of a known weight and that the liquid is  
 of a known volume. The method of measuring the change in weight  
 of the solid is described in detail, and it is shown that it is  
 possible to determine the rate of reaction with an accuracy of  
 one part in a hundred. The method of measuring the change in  
 weight of the solid is also applicable to cases in which the solid is  
 of a known weight and the liquid is of a known volume. The method  
 of measuring the change in weight of the solid is described in detail,  
 and it is shown that it is possible to determine the rate of reaction  
 with an accuracy of one part in a hundred. The method of measuring  
 the change in weight of the solid is also applicable to cases in which  
 the solid is of a known weight and the liquid is of a known volume.

J. H. P. 1913

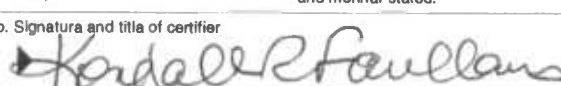
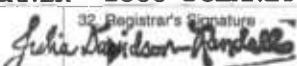
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13492

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BEVERLY S. OSTENDORF</b>				2. Date of Death Month Day Year <b>MAY 06, 1996</b>		3. Time of Death <b>8:37 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-07-0340</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 29, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>715 Maiden Choice Lane PV511</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Edward Eugene Sullivan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Violet Elizabeth Shoul</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen O. Ford (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Mayapple Court Baltimore, Maryland 21286</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>May 9, 1996</b> <b>Md. Veterans Cemetery</b>		20c. Location - City or Town, State <b>Owings Mills, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Witzke Funeral Homes Of Catonsville, Inc.</b> <b>1630 Edmondson Avenue Catonsville, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>BONE METASTASIS</b> Due to (or as a consequence of):  b. <b>BREAST CANCER</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death  <b>YEARS</b>  <b>11 YEARS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>025043</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

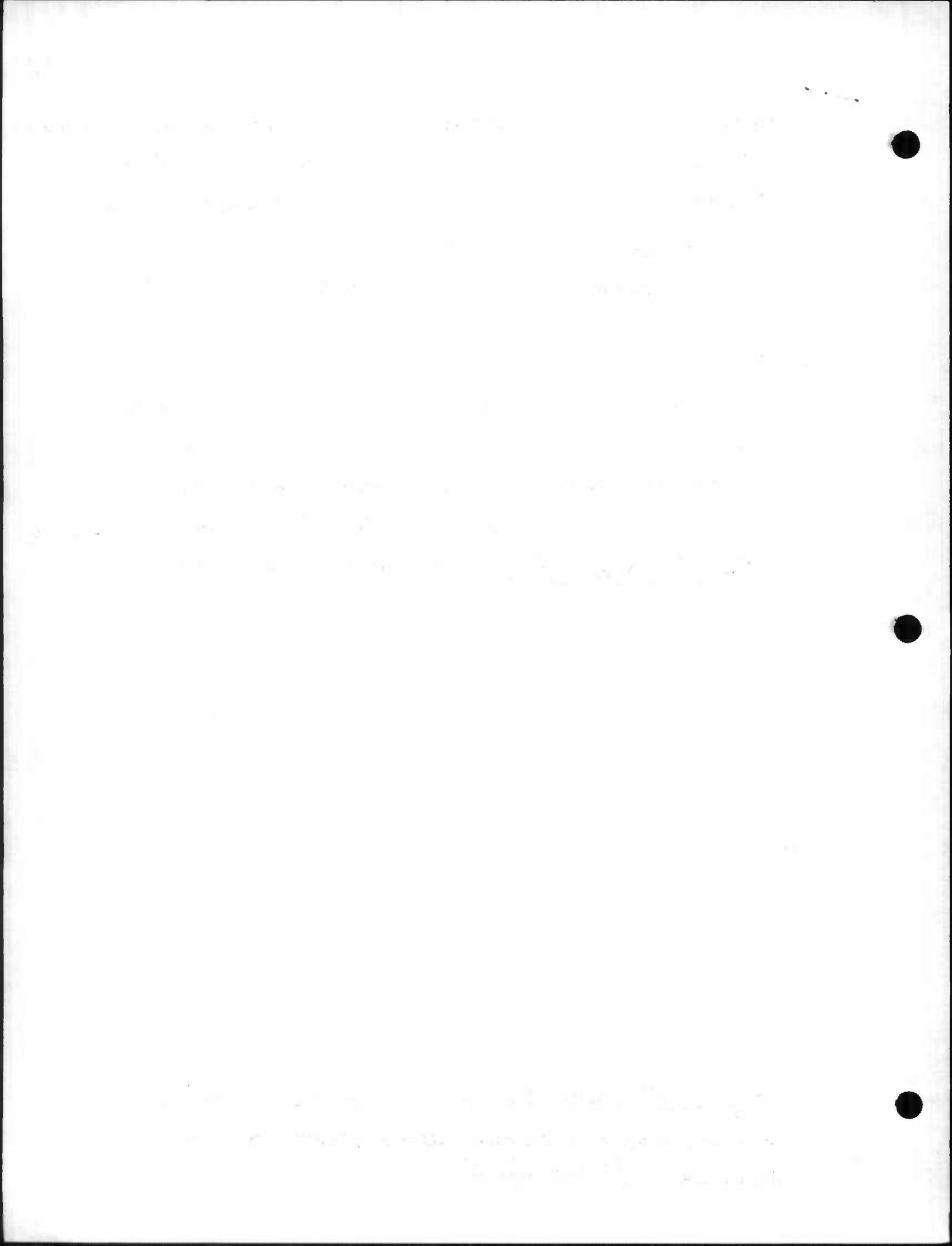
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LEONARD CHIFNEY PUCKETT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 3, 1996</b>		3. TIME OF DEATH <b>1:05 P. M</b>	
4. SOCIAL SECURITY NUMBER <b>220-05-4388</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-19-1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CATON MANOR NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>	
10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>215 PLYMOUTH LANE, APT. C</b>	
10f. ZIP CODE <b>21061</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1924-1928</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERINTENDENT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B &amp; O RAILROAD</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WELLINGTON BRAGG PUCKETT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE MOSMILLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>THOMAS BENJAMIN PUCKETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5826 FOREST HILL ROAD, ELKBRIDGE, MD. 21227</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK 5/6/96</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Gaffigan</i>				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Bladder Carcinoma</b>							
Due to (or as a consequence of): <b>b. Chronic Renal Failure</b>							
Due to (or as a consequence of): <b>c.</b>							
Due to (or as a consequence of): <b>d.</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William M. Attending Doctor</i>				29c. LICENSE NUMBER <b>D21684</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-3-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CV. CYRIAC-M.D 1600 CRAIN HWY, GLENBURNIE. MD 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68700

DIVISION OF VITAL RECORDS, P.O. BOX 68700

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





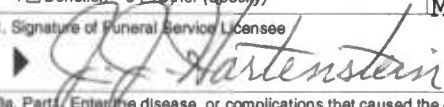

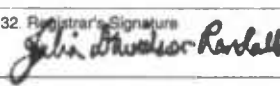
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13494

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hensel Leon Phillips</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>				3. Time of Death <b>10:30 PM</b>					
	4a. Facility Name (If not Institution, give street and number) <b>1807 Mt. Carmel Rd.</b>				4b. City, Town, or Location of Death <b>Parkton</b>				4c. County of Death <b>Baltimore</b>					
Funeral Director	5. Social Security Number <b>219-16-8017</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>June 23, 1919</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkton</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>1807 Mt. Carmel Rd.</b>				10f. Zip Code <b>21120</b>				10g. Citizen of What Country? <b>U.S.A.</b>						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>				16b. Kind of Business/Industry <b>Tool Manufacture</b>				
17. Father's Name (First, Middle, Last) <b>Ernest Phillips</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Layman</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Naomi I. Morfoot</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4217 Black Rock Rd., Upperco, MD 21155</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>				Date <b>May 6, 1996</b>		20c. Location - City or Town, State <b>Timonium, MD 21093</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Lung Cancer</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		29d. Describe how Injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D 19166</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dr. J. Allen Baldanza, 10629 York Rd., Cockeysville, MD 21030</b>														
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

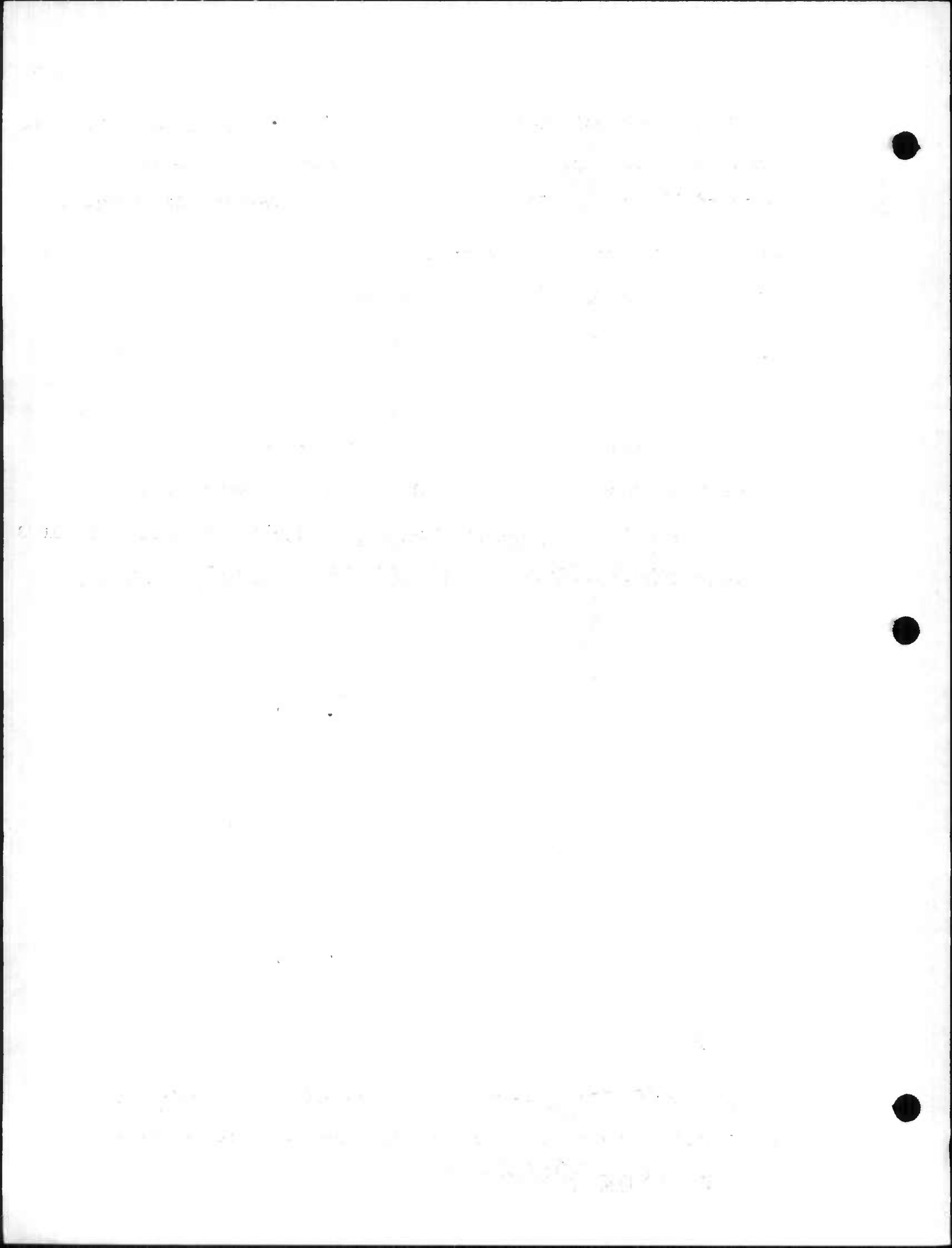
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 13495

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS ILENE PERRY				2. Date of Death Month Day Year MAY 3, 1996		3. Time of Death 12:20 P.M.	
	4a. Facility Name (If not institution, give street and number) ALLEGIS HEALTH & REHABILITATION CENTER				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 212-05-1415		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 06-25-1909	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MARYLAND		10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1907 SURF CIRCLE				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TELEPHONE OPERATOR		16b. Kind of Business/Industry C & P TELEPHONE CO.			
	17. Father's Name (First, Middle, Last) JOSEPH THOMAS				18. Mother's Name (First, Middle, Maiden Surname) CLARA SEIPP			
	19a. Informant's Name/Relationship (Type, Print) MRS. JANICE L. SELIG				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7969 SHETLAND DELL CT., GLEN BURNIE, MD. 21061			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY		20c. Location - City or Town, State 5/6/1996 BELTSVILLE, MD.			
	21. Signature of Funeral Service Licensee <i>Michael C. Saffian</i>				22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
	23a. Pertinent disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Whymore M7</i> Attending Doctor				29c. License number D 21684		29d. Date signed (Month, Day, Year) 5-4-96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C.V. CYRIAC MD 1600 CRAIN AVE #106, GLENBURNIE, MD 21061								
31. Date filed (Month, Day, Year) MAY 08 1996				32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 13496

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Yolanda Pinto</u> Yolanda Pinto				2. DATE OF DEATH MONTH <u>May</u> DAY <u>3</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>12:00 P.M.</u>	
4. SOCIAL SECURITY NUMBER 201-30-0735		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 19, 1908	
8a. FACILITY NAME (If not institution, give street and number) Lorian Nursing Home				8b. CITY, TOWN OR LOCATION OF DEATH Columbia		8c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6334 Cedar Lane				10f. ZIP CODE 21044		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Alessandro Scarpa				18. MOTHER'S NAME (First, Middle, Maiden Surname) Guisepina Unknown			
19a. INFORMANT'S NAME (Type/Print) Angela Morgan				19b. MAILING ADDRESS 4037 Arjay Circle, Ellicott City, Md 21042			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sts Peter & Paul Cem 5/8		20c. LOCATION — City or Town, State Springfield, Pa			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto, Md 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Alzheimer's Disease</u>					
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William Flowers MD</u>				29c. LICENSE NUMBER D20789		29d. DATE SIGNED (Month, Day, Year) May 3, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Flowers MD 11055 Little Patuxent Pkwy Columbia MD							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13497

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lloyd V. Peacock</i>				2. Date of Death Month <i>May</i> Day <i>3</i> Year <i>1996</i>		3. Time of Death <i>12:45 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Tops of Evergreen N.H.</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NIA</i>	
Funeral Director	5. Social Security Number <i>246-16-2820</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 4, 1917</i>		9. Birthplace (State or Foreign Country) <i>N.C.</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>NA</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>4012 Spruce Drive</i>			10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th grade</i> College (1-4or 5+) <i>NA</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer</i>			16b. Kind of Business/Industry <i>Manufacturing</i>		
	17. Father's Name (First, Middle, Last) <i>Troy Peacock</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Della</i>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Peggy A. Peacock - Niece</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4012 Spruce Drive Baltimore, MD 21215</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i>		Date <i>5-10-96</i>		20c. Location - City or Town, State <i>Randallstown, MD</i>	
	21. Signature of Funeral Service Licensee <i>Wesley Edmon</i>			22. Name and Address of Facility <i>March 15 H. West 4300 Walbrook Avenue Baltimore, MD 21215</i>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Lung Ca</i> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death <i>6 months</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CVA, HBP, CHF</i>							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>MD</i>						
29c. License number <i>027569</i>		29d. Date signed (Month, Day, Year) <i>5/7/96</i>						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Allen Hettelman 1777 Reisterstown Rd #365</i>								
31. Date filed (Month, Day, Year) <i>MAY 08 1996</i>		32. Registrar's Signature <i>Johia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1945

1946

1947

1948



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13498

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret

E.

Pensker

2. Date of Death

Month

Day

Year

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

332 Patterson Park Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-70-3408

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec 17, 1906

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3217 E. Fairmount Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Dougherty

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Ogle

19a. Informant's Name/Relationship (Type, Print)

Elizabeth McDonough/Daugh

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8026 Caradock Drive, Balto, Md. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn

Date

5/6

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Phyllis Stacks

22. Name and Address of Facility

Moran Ashton Funeral Home

3000 E. Baltimore Street, Balto, Md 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE END STAGE DEMENTIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

ARTERIOSCLEROTIC CORONARY ARTERY DISEASE

HISTORY OF CIGARETTE SMOKING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. M. Nixoff MD ATTENDING PHYSICIAN

29c. License number

029197

29d. Date signed (Month, Day, Year)

5/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. M. NIXOFF MD 9000 FRANKLIN SQUARE PR. BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

J. M. Nixoff

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 13499

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES B. QUADE</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>3</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4 30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-03-1694</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 23, 1913</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>ST. ELIZABETH'S NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3223 ROSALIE ROAD</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH GRADE</b> College (1-4 or 5+) <b>COLLEGE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COIL WINDER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ELECTRICAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JULIUS A. QUADE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARION A. BROWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLIAM QUADE, JR. (GRAND-NEPHEW)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17044 WESLEY CHAPEL ROAD-MONKTON, MD 21111</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place) <b>LAKEVIEW MEMORIAL PARK</b>		DATE		20c. LOCATION — City or Town, State <b>SYKESVILLE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Debra R. Klug</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hypertensive Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>20 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid Arthritis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William M. Russell</i>				29c. LICENSE NUMBER <b>D30182</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 3, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM M. RUSSELL M.D. 3320 BENSON AVE BALTIMORE MD 21227</b>							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 13500

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gregg C. Rife				2. Date of Death Month Day Year Apr. 29 1996		3. Time of Death 8:30 PM													
	4a. Facility Name (If not Institution, give street and number) 6610 Seneca Drive				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard													
Funeral Director	5. Social Security Number 229-36-1280		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 4-20-1932													
	9. Birthplace (State or Foreign Country) Michigan		10a. State MD.		10b. County Howard		10c. City, Town or Location Columbia													
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6610 Seneca Drive		10f. Zip Code 21046		10g. Citizen of What Country? USA													
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-55		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) systems analyst		16b. Kind of Business/Industry Dept. of Defense															
	17. Father's Name (First, Middle, Last) Rolland H. Rife				18. Mother's Name (First, Middle, Maiden Surname) Eva Mae Seward															
	19a. Informant's Name/Relationship (Type, Print) Nancy R. Rife wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Seneca Drive, Columbia, Md. 21046															
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Date 4/30/96		20d. Location - City or Town, State Catonsville, Md.													
	21. Signature of Funeral Service Licensee May K. Marshall				22. Name and Address of Facility Witzke Funeral Homes, Inc. of Columbia 5555 Twin Knolls Rd., Columbia, Md. 21045															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Respiratory Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 5 days</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. Aspiration Pneumonia</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Lung Cancer Stage IV</td> <td rowspan="4">2 weeks</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> <tr> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	Approximate Interval Between Onset and Death 5 days	Due to (or as a consequence of):	b. Aspiration Pneumonia	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Lung Cancer Stage IV	2 weeks	Due to (or as a consequence of):	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	Approximate Interval Between Onset and Death 5 days																	
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	Due to (or as a consequence of):																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic anemia, Anorexia - Cachexia Brain metastasis																				
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																				
28a. Date of Injury (Month, Day Year) 28b. Time of injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier Jon K. Marshall MD 29c. License number D30573 29d. Date signed (Month, Day, Year) 4-30-96																				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Jon K. Marshall, MD 2 Knoll North, Columbia MD 21045																				
31. Date filed (Month, Day, Year) MAY 08 1996																				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

